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ABSTRACT

This monograph provides a collection of articles on health educators' approaches to advocacy: "The Role of Health Education Advocacy in Removing Disparities in Health Care" (John P. Allegrante, Donald E. Morisky, and Behjat A. Sharif); "The Role of Health Education Associations in Advocacy" (M. Elaine Auld and Eleanor Dixon-Terry); "What Legislators Need from Their Constituents Regarding Advocacy Efforts: A View from the Inside" (Louis Patrick Crocco); "Youth Advocacy: The Florida Tobacco Prevention Model" (David F. Foulk and Stephen A. Rollin); "Advocacy Issues among Native Americans" (Linda Bane Frizzell); "Advocacy in Action: One Person's Experience" (Fern Walter Goodhart); "Advocacy Groups for Hispanic/Latino Health Issues" (Helda Pinzon-Perez and Miguel A. Perez); "How To Effectively Use the Internet for Advocacy" (Mark Temple); "Putting Advocacy in Action" (Susan E. Ward and Nancy L. Koontz); "Media Advocacy: A Tool for Health Education" (Linda Weiner); and "Partners for Advocacy: Non-Profit Organizations and Lobbyists" (Susan Frelick Wooley, Scott Ballin, and Sherri Reynolds). (SM)

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1999

The Health Education Monograph

Series

Approaches to Advocacy for Health Educators

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The Health Education Monograph Series

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Foreword

As the profession of Health Education has developed, grown, and progressed over the past several decades, so have Health Educators' various roles, responsibilities, and career paths. While we are a diverse profession in many ways, we also share some vital unifying beliefs, activities, and processes. Perhaps one area that is equally relevant to health educators in all settings, at all levels, and with multiple and varied job descriptions, is that of advocacy.

Just as our profession is multifaceted, so is the practice of advocacy. In this issue of the **Eta Sigma Gamma Monograph Series**, we have attempted to provide you with an array of perspectives about the increasingly important area of advocacy. This issue of the **Monograph Series** is, in some ways, a bit different than its predecessors. Our intent was to provide you with a "general store," rather than a "specialty shop" approach to the topic. In other words, we have not limited the type of contribution or the perspective of the articles. On the contrary, we have included a variety of topics; each in its own way designed to assist you in your understanding of the larger picture of advocacy. We hope there is something here for everyone.

We invite you to enjoy, and use, the contents of this issue, from cover to cover. For example, Elaine Auld's article, The Role of Health Education Associations in Advocacy, and the contribution from Susan Wooley, Scott Ballin, and Sherri Reynolds, Partners for Advocacy: Non-Profit Organizations and Lobbyists both provide excellent histories of many of our professional organizations as they relate to advocacy efforts. They are intended to refresh your memory, or bring you up to speed regarding the ways in which our professional organizations can be effective in this sphere.

John Allegrante, Donald Morisky, and Behjat Sharif, in The Role of Health Education Advocacy in Removing Disparities in Health Care, describe the disparities in health status among disadvantaged populations. Their account of the contributing factors and selected examples of advocacy efforts is comprehensive and timely.

Our current president, Susan Ward, and former executive committee student member, Nancy Koontz, have presented a summary of Eta Sigma Gamma's involvement in the national advocacy summits of 1998 and 1999. Their article, Putting Advocacy into Action, highlights some specific steps that can be taken to advance a specific cause.

Two articles are directed toward selected minority issues. Helda Pinzon-Perez and Miguel Perez, in Advocacy Issues Among Hispanic/Latino Populations, have provided an excellent summary of available resources for those interested in advocacy for Hispanic/Latino populations. In the article Advocacy Issues Among American Indians, Linda Bane Frizzell has contributed an eloquent account of the history of American Indian health issues, and the advocacy that is needed in this arena.

To provide readers with a better understanding of what advocacy looks like from a legislative point of view, Attorney Lou Crocco's article, What Legislators Need from Their Constituents Regarding Advocacy Efforts: A View from the Inside provides a perspective regarding what is most important to those who represent us. He has supplied most helpful insights.

Mark Temple's article, How to Effectively Use the Internet for Advocacy, shares tips for readers as to how you can best use the technology available to reach your legislators in an effective, timely, and comprehensive manner.

Media are an important component in advocacy, and Linda Weiner's article, Media Advocacy: A Tool for Health Education, shares perspectives on this facet of the overall advocacy effort.

Fern Goodhart has shared her story "from the trenches" about how a grassroots advocacy effort was born. Her first hand account, in Advocacy in Action: One Person's Experience details the process she experienced becoming an advocate. It is an inspiration to those who might think they can't make a difference as single voices.

David Foulk and Stephen Rollin have provided a case-specific account of the process in Florida surrounding advocacy and the tobacco issue. Their article, Youth Advocacy: The Florida Tobacco Prevention Model, is an excellent account of this initiative.

The contributions herein represent great effort on the part of the authors, and we extend our thanks to them for contributing their expertise, their valuable time, and their dedication to Health Education Advocacy efforts. We wish you good reading, and, perhaps more important, we wish you the best in your advocacy efforts. We hope you will use this information to spur you on, at whatever level and for whatever purposes you most immediately need to make your voice heard.

Best regards,
Beverly Saxton Mahoney, PhD, CHES, and Kelli McCormack-Brown, PhD, CHES
Guest Editors, The Health Education Monograph Series

Preface

On behalf of the National Executive Committee of Eta Sigma Gamma (ESG), I would like to express my sincere appreciation to the Guest Editors of this issue, Dr. Beverly Mahoney and Dr. Kelli McCormack-Brown, for the significant contribution they have made to the profession and Eta Sigma Gamma. Collaboratively, they have done a wonderful job in preparing and editing this timely, first-class monograph on advocacy. This is an excellent issue examining the concept and different perspectives on advocacy. By their actions, these two guest editors exemplify what health education advocacy should be. Dr. McCormack-Brown and Dr. Mahoney not only "talk the talk", but also "walk the walk." They are two committed leaders and vocal advocates of health education. For their contributions, they deserve our sincere thanks. Further, I would like to thank all of the authors who ultimately made this monograph possible. I genuinely appreciate their contributions to the **Health Education Monograph Series.**

I would like to thank Ms. Kathy Finley for her assistance in preparing the publication and Ms. Joyce Arthur for her technical assistance. Also the assistance of Mr. Jay Javed from our National ESG office is appreciated. Last, but not least, I would like to offer my appreciation to each and every member of the National Executive Committee who are very committed to supporting the monograph series.

Finally, thank you for sharing your comments with me regarding the past Monograph series. As always, I am eager to hear your criticisms, comments, and suggestions regarding these publications. Your input is essential in improving the publication and ultimately serving our members and the profession in the most effective way. I do hope that you, as loyal members of this National Professional Health Education Honorary, check your college/university libraries to make sure they receive ***The Health Education Monograph Series***. If not, please request that they subscribe to these important publications by calling 1-800-715-2559. It is a privilege for me to serve the Eta Sigma Gamma members and our profession.

I look forward to hearing from you.

Mohammad R. Torabi, Ph.D., MPH, CHES
Editor, ***The Eta Sigma Gamma Monograph Series***

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The Role of Health Education Advocacy in Removing Disparities in Health Care

John P. Allegrante, Ph.D., Donald E. Morisky, Sc.D., M.S.P.H. & Behjat A. Sharif, Ph.D.

Introduction

Since the founding of the Centers for Disease Control and Prevention over 50 years ago, people in the United States have experienced unprecedented improvements in health status. There are now almost one million fewer cases of measles compared to 1941, and 200,000 fewer cases of diphtheria. Average blood-lead levels in children are now less than one-third of what they were in 1976. More than 2 million Americans are alive today who otherwise would have died from tobacco-attributable heart disease and stroke because of the landmark announcement by the Surgeon General in 1964 regarding the threat posed by tobacco. Moreover, efforts to protect the blood supply have now prevented more than 2 million Hepatitis B and C infections and more than 50,000 HIV infections, resulting in savings of more than $3.5 billion in medical costs associated with these three diseases (Turnock, 1997).

Despite these notable achievements in disease control and prevention, there is mounting evidence that disparities in health care have grown unacceptably wide in American society. The disparities between minorities and the white population have increased in the last decade on virtually every measure of health status (U.S. Department of Health and Human Services, 1998a). Consequently, the *Healthy People 2010 Objectives* (U.S. Department of Health and Human Services, 1998b) calls for the elimination of health disparities in six major areas—infant mortality, cardiovascular disease, diabetes, and HIV/AIDS, as well as cancer screening and management and childhood and adult immunizations. Health education advocacy can play an important role in eliminating such health disparities (Montes & Johnson, 1998). Advocacy constitutes the development of coalitions and partnerships, as well as working with the media, to influence political, regulatory, and environmental policies that can improve community health. There are numerous examples of health promotion policy initiatives that have relied on advocacy efforts to influence the tobacco, alcohol, and environmental issues (Green & Kreuter, 1999). Although there is not extensive literature on the use of advocacy to reduce health disparities among disadvantaged populations, Braithwaite and Lythcott (1989) and Thomas (1990) have argued that community empowerment strategies are critical to health promotion for African-Americans and other minorities.

This paper will first summarize the mounting evidence of disparities in health status and access to health services across disadvantaged American populations. Next, we review some of the major contributing factors to these health disparities. We then highlight selected examples of advocacy approaches that have been conceptualized and implemented in health education efforts. Finally, we conclude by discussing the role of advocacy aimed at eliminating the health disparities that persist among the disadvantaged.

Disparities in Health Status and Access to Health Services

Despite notable progress in achieving many of the national goals and objectives for the improvement of overall health status, there are persistent disparities in the burden of illness and death experienced by African-Americans, Hispanics and Latinos, American Indians and Alaskan Natives, and Pacific Islanders. According to the U. S. Department of Health and Human Services (1998c), these disparities are even greater when comparisons are made between each racial and ethnic group and the U.S. population as a whole.

- Infant mortality rates are two and a half times higher for African-Americans and one and a half times higher for Native Americans than for Caucasian Americans.
- African-American men under 65 years of age suffer from prostate cancer at nearly twice the rate of Caucasians.
- Heart disease, the leading cause of death and a common cause of morbidity in the U.S., occurs at nearly twice the rate in African-American men compared to Caucasian men. The age-adjusted death rate for coronary heart disease for the total population declined by 20 percent from 1987 to 1995, but for blacks, the overall decrease was only 13 percent. Compared with rates for whites, coronary heart disease mortality was 40 percent lower for Asian-Americans but 40 percent higher for blacks in 1995.
- Native Americans suffer from diabetes at nearly three times the average rate, while African-Americans suffer 70 percent higher rates than Caucasians; the prevalence of diabetes in Hispanics is nearly double that of Caucasians.
- Racial and ethnic minorities constitute approximately 25 percent of the total population, yet they account for nearly 54 percent of all AIDS cases.

Such disparities in health status, however, are not constrained to racial and ethnic minority groups. The disparities have become increasingly evident for women, people

with low incomes, people with disabilities, and specific age groups, including children, adolescents, and the elderly, as well as by geographic location.

Major Contributing Factors to Health Disparities

The causes of health disparities have long been of interest to epidemiologists, sociologists, and public health professionals. Among the major contributing factors to these disparities are race and ethnicity, socioeconomic status, gender, age, geographic location, insurance coverage, and political will.

Race and Ethnicity

Health disparities by race and ethnicity are especially pronounced among Americans (Council on Ethical and Judicial Affairs, 1990). For example, studies have found that African-American men living in Harlem have a life expectancy that is less than that of men living in Bangladesh (McCord & Freeman, 1990); that there are dramatic racial differences in preventable deaths in the Medicare population (Woolander et al., 1985); that race can influence the stage at diagnosis for endometrial cancer (Barrett et al., 1995), as well as colon cancer survival (Mayberry et al., 1995); and that the prevalence of arthritis and other potentially disabling musculoskeletal conditions is higher in African-Americans than other groups (Charlson, Allegrante & Robbins, 1993).

In addition, numerous studies have documented disparities in access to health services. Studies of access by African-Americans to emergency room services (Perkoff & Anderson, 1970), health and hospital services (Gornick, et al., 1996; Yergan, Flood, LoGerfo, & Diehr, 1987), organ transplantation (Kasiske et al., 1991), total joint replacement (Katz, Freund, Heck, & Dittus, 1996), and treatment for chest pain and recommendations for cardiac catheterization (Schulman et al., 1999) have all suggested that race independently influences access to health services that can reduce morbidity and mortality and prevent disability.

Disparities also exist in the prevalence of risk factors. For example, racial and ethnic minorities have higher rates of hypertension, tend to develop hypertension at an earlier age, and are less likely to undergo treatment to control their high blood pressure. From 1988 to 1994, 35 percent of black males ages 20 to 74 had hypertension compared with 25 percent of all men. When age differences are taken into account, Mexican-American men and women also have elevated blood pressure rates. However, the results of recent studies (Morisky & Ward, 1999; Ward, Morisky, Lees, & Fong, in press) have demonstrated that both African-American and Hispanic populations can benefit dramatically from community-based educational programs that utilize targeted and tailored approaches to blood pressure control.

Similarly, although significant effort has been made to reduce the overall U.S. infant mortality rate, a significant indicator of a nation's overall health status, marked disparities between minority groups and Caucasians persist. Puerto Ricans, Hawaiians, American Indians and African-American infants suffer higher mortality rates, 26%, 33%, 55% and 112% respectively, compared to Caucasian infants.

While the mechanism by which race and ethnicity influence health status may not be clear, it is entirely possible that perceived systematic discrimination may play an important causative role in diseases such as hypertension. Ren, Amick, & Williams (1999) have noted that the experiences of discrimination tend to have a strong negative association with health and that much more work needs to be done to specify the social distribution of discrimination and assess its consequences for health status in people of color.

Socioeconomic Status

The contribution of socioeconomic status to health disparities has been well documented (Adler, Boyce, Chesney, Folkman, & Syme, 1993; Pappas, Queen, Hadden, & Fisher, 1993). Socioeconomic factors, including education, income, and occupation, are strongly associated with health and trends in health status in both individuals and populations (Kaplan, 1998). For example, maternal education and family income both inversely affect infant mortality (Singh & Yu, 1995). In addition, income inequality is not only a major determinant of infant mortality, but also life expectancy at birth (Smith, 1996).

Navarro (1997) states that differences in morbidity and mortality rates are related to social class and, in fact, these differentials are much larger by class than by race. For example, blue-collar workers mortality rate for heart disease has been found to be 2.3 times higher than that of Caucasian-collar professionals. However, mortality rates for heart disease in African-American males and females were respectively 1.2 and 1.5 times higher than their Caucasian counterparts. Those making $10,000 or less per year encountered 4.6 times more morbidity than those making over $35,000, while African-Americans' morbidity rate was 1.9 times higher than that of Caucasians (Navarro, 1997).

Generally, minorities, who are among the lowest-paid, poorly-educated working class, continue to have morbidity and mortality rates higher than those who are well-educated and well-paid. In addition, the low-paid population's standard of living has been deteriorating due to the growing inequity in income and wealth between the upper and lower classes. Navarro (1997) reports that the lower class of the population (40%) received 15.7 percent of the total income while the wealthiest of the population (20%) received 42.9 percent of total income. Thus, the growing gap in the nation's health clearly cannot be understood and remedied by examining individual differences by race and ethnicity alone.

The relationship of poverty to poor health is well established (Kawachi, Kennedy, Lochner, & Prothrow-Smith, 1997;

Wilkinson, 1997). Being impoverished, however, not only results in destruction of individual health, but also in the social, physical and mental decay of generations. High mortality rates for both children and adults are directly related to poverty as well as income inequality. For example, the population death rate in North America attributable to poverty increased between the early 1970s and early 1990s. Moreover, the surge in the local incidence of some diseases, such as tuberculosis in New York City, during the last decade has been linked to poverty (Hamburg, 1993). Hence, it is not surprising to find observers such as Poland, Coburn, Robertson, & Eakin, (1997) and Tesh (1988) arguing that the political economy is a major determinant of health and illness.

Choice of occupation may also influence health (Karasek & Theorell, 1990; Tesh, 1988). For example, occupations that are characterized as high demand and low control have been correlated with coronary heart disease. In addition, low-paying jobs often involve exposure to harmful substances, require potentially repetitive motion or entail exposure to potentially dangerous equipment and machinery, or other unhealthy situations. Thus, improvements in occupational health should not only focus on redesigning jobs but examine why many current work designs generally result in such an excessive demand and insufficient level of job control.

Unfortunately, the scientific, multi-causal approach to analyzing the etiology of diseases often does not specify the contribution of fundamental factors, such as social condition, in the causal nexus of poor health (Tesh, 1988). Historical records support the notion that the origins of diseases have been largely social in nature. In the case of epidemics, what data are available suggest a clear linkage between disease and the conditions under which people live. For example, Lantz et al. (1990) indicate that socioeconomic differences in mortality are due to social-structural factors and that high mortality could persist despite improved health behaviors among the poor. Similarly, Minkler (1999) has argued that while we need not abandon concepts of personal responsibility for health, focusing on the broader social responsibility for health is necessary if we are to improve health.

The foregoing suggests that effective disease prevention not only seeks to identify the specific agent, web of causation, or personal actions, but also the more fundamental political and economic causes of disease and those factors that may result in an unequal distribution of power and resources. Those with secure employment, a good education, adequate medical care, and regular leisure activities do not develop diseases that plague the impoverished. Consequently, satisfying jobs, decent housing, and good schools serve as strong factors in disease prevention and should be targets of intervention if we are to reduce disparities in health.

Gender

Women are more likely than men to bear a significantly greater proportion of the burden of disease and illness in American society. Since the 1970s there has been considerable interest in the relative health of women and men and the extent to which gender differences play a role in determining the health status of Americans and Western Europe ans (Hunt & Annandale, 1999). While there is consensus that gender disparities in health continue to be mediated to some degree by women's unequal status in society (Cook, 1994; Doyal, 1995; Fee & Krieger, 1994), in addition to the inherent physiological differences that influence their proclivity to greater disability and morbidity than males (Arber & Cooper, 1999; Belgrave, 1993; Graham, 1998), a noteworthy recent finding by Kawachi, Kennedy, Gupta, & Prothrow-Smith, (1999) is that indices of American women's health status strongly predict both American male and female mortality rates. Severe marital violence is also highest in those states where gender inequality is the highest.

Another important observation documented by Bayne-Smith and McBarnette (1996) is that among women in the United States, the particular disparities that have limited the intellectual growth of minority women, arguably account, in part, for their inferior health status, both physical and mental, when compared to their more well-endowed Caucasian counterparts and males who live in poverty. Indeed, Roberts (1999) found African-American female adolescents who were poor and living in inner cities to bear a disproportionate burden of poor health outcomes compared to white women. As such, interdisciplinary collaborations examining the structural inequities and combined consequences of sexism, racism, and inner-city poverty for young women of color are necessary to inform public health interventions designed to improve the health of African-American female adolescents.

In addition to societal-wide inequities in health status generated by gender discrimination, gender inequities in access, particularly to quality prenatal care, have a strong bearing on the health status of infants. There is a two-fold risk of sudden infant death in American minority populations (Hill, 1999). Moreover, gender may also influence access and exposure to material and other resources differentially and inequitably (Stacey & Olesen, 1993).

Age

An excess of morbidity with more severe domains of poor health is likely to be found among elderly people. Work by Fitzpatrick and Van Tran (1997), who have studied the effects of age, gender, and health among African-Americans, found both the objective and subjective dimensions of health to vary according to age, but that the effects of age on health status were not the same for men and women at any age. Older women are, however, substantially more likely to experience functional impairment in mobility and self-care than men of the same age (Arber & Cooper, 1999; Belgrave, 1993).

Inner-city older blacks also have higher levels of functional disability than whites of a comparable age and black adults in other regions, regardless of gender, as well as increased body

fat, and lower levels of dental care, along with high levels of visual and hearing impairments (Miller et al., 1996). However, age disparities in medical treatment are more likely to affect females because they are less likely than males to receive available treatments for cardiac, renal, and other conditions (Belgrave, 1993).

In addition, economic inequities are extremely detrimental to older females. This is supported by Smith and Kington (1997), whose research demonstrated health outcomes at old age with respect to race and ethnicity are influenced by economic differences. Similarly, there are striking inequalities in susceptibility of minority children to infectious diseases whose consequences may stretch into adulthood (Reading, 1997). This finding supports the view that environmental and material factors have a strong influence on health. Consequently, Reading favors an emphasis on structural and community-wide policy interventions that remove disparities, rather than intervention directed solely at changing individual behavior.

Geographic Location

Geographic location may also play a role in contributing to health disparities. For example, there is growing evidence that urban populations bear a significantly greater proportion of disease burden due to problems such as asthma (Crain et al., 1994), HIV infection (Holmberg, 1996), and lead poisoning (Sargent et al., 1995), than do those living in suburban or rural areas. In addition, studies of the delivery of health services, including the treatment of acute myocardial infarction (O'Connor et al., 1999), total hip replacement (Peterson et al., 1992), and other common surgical procedures (Birkmeyer et al., 1998) have shown dramatic variations in access to preventive services, medical treatment, and surgical procedures by geographic location.

Insurance Coverage

According to Blendon et al. (1994), research has documented that decreased access to health care services, increased burden of economic hardship, poor health, and excess mortality are experienced by the uninsured and underinsured. Moreover, wide gaps in insurance coverage between racial and ethnic groups in America exacerbate the experience for minorities. For example, in a recent study conducted in California, rates of uninsured residents in 1997 amounted to 15 percent for Caucasians, 19 percent for African-Americans, 24 percent for Asian Americans, and 38 percent for Latinos. Just 41 percent of Latinos in California were found to have job-level coverage, compared to 69 percent of Caucasians. The major reason for the high uninsured rates by ethnicity is affordability. The response most often given by the majority of Caucasians and Latinos when asked why they are not insured is that it was too expensive (Brown, 1996). In addition, despite the role that Medicaid has played in improving access to care, minority children still have a poorer quality of life than whites (Hall, 1998). Thus, improving access to health services will require eliminating the gaps in insurance coverage that still persist for the one out of four Americans who is either uninsured or underinsured.

Political Will

Unfortunately, the basic questions that characterized the debate on health-care reform of the early 1990s have remained unanswered. Unlike the historical lack of understanding about public health, Americans have recently raised questions about effectiveness, efficiency, and cost of the health-care system. However, policy makers appear to take their cues from other sources and may not have the political will to do what is necessary to eliminate the disparities in health. Lee and Estes (1997) have argued that the most powerful constituencies in health care continue to be physicians, hospitals, insurance companies, and pharmaceutical industries. Although these groups appear to be concerned about the quality of care, they are generally more interested in surviving in the increasingly market-driven health care system than changing the system to make it more responsive to the health needs of an increasingly diverse America.

To make matters worse, although there is a consensus about the nature of the problems in the health-care system, there is little agreement on what should be done to correct them (Lee & Estes, 1997). At the federal and state level, prevention has emerged as an important goal of health policy, yet prevention is still competing for a more equitable share of national resources (Allegrante, 1999). Whether policy makers will have the political will to shift resources from the investments that have historically been made in medical care to creating the community capacity and other resources necessary to eliminate the disparities in health status between poor and those who have considerably greater economic means remains to be seen.

Some Examples of Health Education Advocacy

Health educators have pioneered the use of advocacy to improve health and social conditions. The role of political advocacy in shaping public policies that can influence health can be found in the seminal writings of Freudenberg (1978), McKinlay (1993), Minkler and Cox (1980), Steckler & Dawson (1982), Steckler, Dawson, Goodman, & Epstein, (1987), and Wallerstein and Bernstein (1988). In addition, media advocacy, which is designed to alter the way in which the media frames its coverage of health issues and to provide a means by which a social or public policy initiative can be advanced, has been conceptualized by Jernigan and Wright (1996) and Wallack (Wallack, 1997; Wallack & Dorfman, 1996). Below we review some examples of advocacy from the health education literature.

Environment

A number of efforts have been made by health educators

and others to use advocacy to bring about community-based political change and support for environmental policies. These have included health education advocacy and community coalitions to reduce lead poisoning in New York City (Freudenberg & Golub, 1987), improve the housing conditions in an urban, low-income neighborhood through community development (El-Askari et al., 1998), and prevent urban arson at Halloween (Maciak, Moore, Leviton, & Guinan, 1998).

Tobacco Control

Recent tobacco control initiatives in several states, including California, Minnesota, Texas, and Florida, have been the result of intense advocacy by public health groups. These initiatives have stimulated activities at the local, county, and state levels through community coalitions and partnerships, which have resulted in legislative initiatives supporting the regulation and control of tobacco products. Such advocacy efforts have led to public information, building community awareness of the tobacco problem, and policy and ordinance development within establishments (Blaine et al., 1997), as well as media advocacy related to cardiovascular disease risk reduction (Schooler, Sundar, & Flora, 1996).

Alcohol

Advocacy has been especially effective in a number of health education efforts to promote responsible use of alcohol and to prevent alcohol-related motor vehicle deaths (DeJong, 1996) and alcohol-related violence against women (Woodruff, 1996). This work has demonstrated that media advocacy can be an effective means by which to increase public awareness of alcohol-related issues and to advance the cause of alcohol-related prevention efforts in the community (Holder & Treno, 1997).

Elderly

One of the first advocacy efforts in health education was Minkler's work to reduce the poor health conditions, social isolation, and powerlessness of low-income elderly residents living in single-room occupancy hotels in the Tenderloin section of San Francisco (Minkler, 1985, 1992; Minkler, Franz & Wechsler, 1982). The Tenderloin Senior Outreach Project utilized individual and community empowerment strategies to build self-reliance and community cohesion among inner-city disadvantaged elderly. Subsequent work by Roe and Minkler and their colleagues has extended the use of concepts of community organizing and advocacy that proved so successful with grandparents in this project (Minkler, Driver, Roe, & Bedeian, 1993; Roe, Minkler & Saunders, 1995).

HIV/AIDS

Advocacy efforts have been utilized for more than two decades to inform the public about the risk of HIV/AIDS and to foster public support for prevention programs in schools (Kreiger & Lashof, 1988) and the general community (Rundall & Phillips, 1990). More recent advocacy approaches have focused on developing consortium approaches to the delivery of HIV services (McKinney, 1993), and have been used to develop community-based HIV prevention programs for Americans of Asian and Pacific Islander backgrounds (Wong, Chng & Lo, 1998). Targeted educational interventions, which have included organizational change policy, directed at female bar workers and the managers of the establishments in which they are employed have demonstrated significant reductions in STD and prevention of HIV infection (Morisky et al., 1998).

Racial and Ethnic Minorities

Advocacy approaches have been used in numerous efforts by health educators and other professionals to reduce health disparities for racial and ethnic minorities. These include reducing teenage pregnancy (Liburd & Bowie, 1989), improving access to health services for the Latino population in St. Louis (Baker et al., 1997), mobilizing minority communities in Indiana to facilitate enactment of legislation for a minority health initiative to reduce preventable disease (Russell, 1997), and developing improved community-wide asthma care for low-income minority populations (Wilson et al., 1998).

Youth Violence

Advocacy has been used as a public health strategy in the prevention of youth violence (Cohen & Swift, 1993). These efforts have resulted in laws being passed at the local and state levels that make it more difficult for young people to purchase handguns and other firearms. A model program that relies heavily on advocacy, and that has been effective in bringing about changes in media coverage of the issues, as well as community and policy change, is the California Violence Prevention Initiative (The California Wellness Foundation, 1994). This multiple-component advocacy effort was designed to reduce violence among youth and young adults. The initiative included policy development, community action programs, leadership development, public education, and research. Through such advocacy, communities throughout California have been able to promote and enact gun-control legislation at both the state and local levels (RAND and Stanford Center for Research in Disease Prevention, 1997).

Conclusion

Despite the overall decline in mortality rates in recent decades, there is persuasive evidence (only a small portion of which could be reviewed here) that disparities in health are

increasing along the lines of race and ethnicity. This is especially troubling given that America's population is projected by demographers to grow even more racially and ethnically diverse in the next century. Advocacy will become increasingly necessary if we are to stimulate the community political action and economic and environmental changes that promise to address the health needs of such a diverse population. In order to eliminate the disparities in health status and access to health services that now exist, however, new knowledge concerning the influence of socioeconomic factors in the causation of disease and the effectiveness of policy-related interventions to alter such factors is required. In the meantime, if we are to have any hope of eliminating disparities in health we need to address the broad socioeconomic determinants of disease that we already know influence health, and we must seek to eliminate those inequities in power and wealth that all available evidence suggests is still at the root of the problem. Health educators can be at the vanguard of this effort by expanding their work to influence community-level and national policy development through advocacy.

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References

Adler, N., Boyce, T. Chesney, M., Folkman, S., & Syme, L. (1993). Socioeconomic inequalities in health. *Journal of the American Medical Association, 269,* 3140-3145.

Allegrante, J. P. (1999). 1998 SOPHE Presidential Address: SOPHE—At the intersection of education, policy, and science and technology. *Health Education & Behavior, 26,* 457-464.

Arber, S., & Cooper, H. (1999). Gender differences in health in later life: The new paradox? *Social Science and Medicine, 48,* 61-76.

Baker, E. A., Bouldin, N., Durham, M., Lowell, M. E., Gonzalez, M., Jodaitis, N., Cruz, L. N., Torres, I., Torres, M., & Adams, S. T. (1997). The Latino health advocacy program: A collaborative lay health advisor approach. *Health Education & Behavior, 24,* 495-509.

Barrett, R. J., Harlan, L. C., Wesley, M. N., Hill, H. A., Chen, V. W., Clayton, L. A., Kotz, H. L., Eley, J. W., Robboy, S. J., & Edwards, B. K. (1995). Endometrial cancer: Stage at diagnosis and associated factors in black and white patients. *American Journal of Obstetrics and Gynecology, 173,* 414-422.

Bayne-Smith, M., & McBarnette, L. S. (1996). Redefining health in the 21st century. In M. Bayne-Smith (Ed.), *Race, gender and health.* Thousand Oaks, CA: Sage Publications.

Belgrave, L. L. (1993). Discrimination against older women in health care. *Journal of Women and Aging, 5,* 181-199.

Birkmeyer, J. D., Sharp, S. M., Finlayson, S. R., Fisher, E. S., & Wennberg, J. E. (1998). Variation profiles of common surgical procedures. *Surgery, 124,* 917-923.

Blaine, T. M., Forster, J. L., Hennrikus, D., O'Neil, S., Wolfson, M., & Pham, H. (1997). Creating tobacco control policy at the local level: Implementation of a direct action organizing approach *Health Education & Behavior, 24,* 640-651.

Blendon, R. J., Donelan, K., Hill, C. A., Carter, W., Beatrice, D., & Altman, D. (1994). Paying medical bills in the United States: Why health insurance isn't enough. *Journal of the American Medical Association, 271,* 949-951.

Braithwaite, R. L., & Lythcott, N. (1989). Community empowerment as a strategy for health promotion for black and other minorities. *Journal of the American Medical Association, 261,* 283-283.

Brown, E. R. (1996). Trends in health insurance coverage in California, 1989-1993. *Health Affairs, 15,* 118-130.

Charlson, M. E., Allegrante, J. P., & Robbins L. (1993). Socioeconomic differentials in arthritis and its treatment. In D. E. Rogers, & E. Ginzburg (Eds.), *Medical care and the health of the poor.* Boulder, CO: Westview Press, pp. 77-89.

Cohen, L., & Swift, S. (1993). A public health approach to the violence epidemic in the United States. *Environment and Urbanization, 5,* 50-66.

Cook, R. J. (1994). *Women's health and human rights.* Geneva: World Health Organization.

Council on Ethical and Judicial Affairs. (1990). Black-white disparities in health care. *Journal of the American Medical Association, 263,* 2344-2346.

Crain, E. F., Weiss, K. B., Bijur, P. E., Hersh, M., Westbrook, L., & Stein, R. E. K. (1994). An estimate of the prevalence of asthma and wheezing among inner-city children. *Pediatrics, 94,* 356-362.

DeJong, W. (1996). MADD Massachusetts versus Senator Burke: A media advocacy case study. *Health Education Quarterly, 23,* 318-329.

Doyal, L. (1995). *What makes women sicker: Gender and the political economy of health.* New Brunswick, NJ: Rutgers University Press.

El-Askari, G., Freestone, J. Irizarry, C., Kraut, K. L., Mashiyana, S. T., Morgan, M. A. & Walton, S. (1998). The healthy neighborhood project: A local health department's role in catalyzing community development. *Health Education & Behavior, 25,* 146-159.

Fee, E., & Krieger, N. (1994). *Women's health, politics, and power.* New York: Baywood Publishing Company.

Fitzpatrick, T. R., & Van Tran, T. (1997). Age, gender and health among African-Americans. *Social Work in Health Care, 26,* 69-85.

Freudenberg, N. (1978). Shaping the future of health education: From behavior change to social change. *Health Education Monographs, 6,* 372-377.

Freudenberg, N., & Golub, M. (1987). Health education, public policy and disease prevention: A case history of the New York City coalition to end lead poisoning. *Health Education Quarterly, 14,* 387-401.

Gornick, M. E., Eggers, P. W., Reilly, T. W., Mentneck, R. M., Fitterman, L. K., Kucken, L. E., & Vladeck, B. C. (1996). Effects of race and income on mortality and use of services among Medicare beneficiaries. *New England Journal of Medicine, 335,* 791-799.

Graham, R. J. (1998). The relationship between sex, gender, and disability: Do women really tend to be more disabled than men? Paper presented at the meeting of the American Sociological Association.

Green, L. W., & Kreuter, M. W. (1999) *Health promotion planning: An educational and ecological approach* (3rd ed.). Mountain View, CA: Mayfield Publishing Company.

Hall, A. G. (1998). Medicaid's impact on access to and utilization of health care services among racial and ethnic minority children. *Journal of Urban Health, 75,* 677-692.

Hamburg, M. A. (1993). Poverty, public health, and tuberculosis control in New York City: Lessons from the past. In D. E. Rogers, & E. Ginzburg (Eds.), *Medical care and the health of the poor.* Boulder, CO: Westview Press, pp. 33-41.

Hill, W. C. (1999). Jumping the broom toward eliminating health disparities: Presidential address. *American Journal of Obstetrics and Gynecology, 180,* 1315-1321.

Holder, H. D., & Treno, A. J. (1997). Media advocacy in community prevention: News as a means to advance policy change. Addiction, 2, S189-199.

Holmberg, S. D. (1996). The estimated prevalence and incidence of HIV in 96 large US metropolitan areas. *American Journal of Public Health, 86,* 642-654.

Hunt, K., & Annandale, E. (1999). Relocating gender and morbidity: Examining men's and women's health in contemporary Western societies. Introduction to special issue on gender and health. *Social Science and Medicine, 48,* 1-5.

Jernigan, D. H., & Wright, P. A. (1996). Media advocacy: Lessons from community experiences. *Journal of Public Health Policy, 17,* 306-330.

Kaplan, G. A. (1998). Socioeconomic considerations in the health of urban areas. *Journal of Urban Health, 75,* 228-235.

Karasek, R., & Theorell, T. (1990). *Healthy work: Stress, productivity and the reconstruction of working life.* New York: Basic Books.

Kasiske, B., Neylan, J., Riggio, R., Danovitch, G., Kahana, L., Alexander, S., & White M. (1991). The effect of race on access and outcome in transplantation. *New England Journal of Medicine, 324,* 302-307.

Katz, B. P., Freund, D. A., Heck, D. A., & Dittus, R. S. (1996). Demographic variation in the rate of knee replacement: A multi-year analysis. *Health Services Research, 31,* 124-140.

Kawachi, I., Kennedy, B. P., Gupta, V., & Prothrow-Stith, D. (1999). Women's status and the health of women and men: A view from the states. *Social Science and Medicine, 48,* 21-32.

Kawachi, I., Kennedy, B., Lochner, K., & Prothrow-Smith, D. (1997). Social capital, income inequity, and mortality. *American Journal of Public Health, 87,* 1491-1497.

Krieger, N., & Laschoff, J. C. (1988). AIDS, policy analysis, and the electorate: The role of schools of public health. *American Journal of Public Health, 78,* 411-415.

Lantz, P., House, J., Lepkowski, J., Williams, D., Mero, R., & Chen, J. (1990). Socioeconomic factors, health behaviors, and mortality: Results from a nationally representative prospective study of US adults. *Journal of the American Medical Association, 279,* 1703-1708.

Lee, P. R., & Estes, C. L. (Eds.). (1997). *The nation's health.* Sudbury, MA: Jones and Barlett.

Liburd, L. C., & Bowie, J. V. (1989). Intentional teenage pregnancy: A community diagnosis and action plan. *Health Education, 205,* 33-38.

Maciak, B. J., Moore, M. T., Leviton, L. C., & Guinan, M. E. (1998). Preventing Halloween arson in an urban setting: A model for multisectoral planning and community participation. *Health Education & Behavior, 25,* 194-211.

Mayberry, R. M., Coates, R. J., Hill, H. A., Click, L. A., Chen, V. W., Austin, D. F., Redmond, C. K., Fenoglio-Preiser, C. M., Hunter, C. P., Haynes, M. A., et al. (1995). Determinants of black/white differences in colon cancer survival. *Journal of the National Cancer Institute, 87,* 1686-1693.

McCord, C., & Freeman, H. (1990). Excess mortality in Harlem. *New England Journal of Medicine, 322,* 173-177.

McKinlay, J. B. (1993). The promotion of health through planned sociopolitical change: Challenges for research and policy. *Social Science and Medicine, 36,* 109-117.

McKinney, M. M. (1993). Consortium approaches to the delivery of HIV services under the Ryan White care act. *AIDS and Public Policy Journal, 8,* 115-125.

Miller, D. K., Carter, M. E., Philip, M. J., Fornoff, J. E., Bentley, J. A., Boyd, S., Rogers, J., Cox, M., Morley, J. E., Lui, Li-Yung, M. A., & Coe, R. M. (1996). Inner-city older blacks have high levels of functional disability. *Journal of the American Geriatric Society, 44,* 1166-1173.

Minkler, M. (1985). Building supportive ties and sense of community among the inner-city elderly: The Tenderloin Senior Outreach Project. *Health Education & Behavior, 12,* 303-314.

Minkler, M. (1992). Community organizing among the elderly poor in the United States: A case study. *International Journal of Health Services, 22,* 303-316.

Minkler, M. (1999). Personal responsibility for health? A review of the arguments and the evidence at Century's end. *Health Education & Behavior, 26,* 121-140.

Minkler, M., & Cox, C. (1980). Creating critical consciousness in health: Applications of Freire's Philosophy and methods to the health care setting. *International Journal of Health Services, 20,* 311-322.

Minkler, M., Driver, D., Roe, K. M., & Bedeian, K. (1993). Community intervention to support grandparent caregivers. *Gerontologist, 33,* 807-811.

Minkler, M., Franz, S., & Wechsler, R. (1982). Social support and social action organizing in a 'grey ghetto': The Tenderloin experience. *International Quarterly of Community Health Education, 3,* 3-15.

Montes, J. H., & Johnson, L. L. (1998). Eliminating health disparities for vulnerable populations through health education intervention within health services programs. *Journal of Health Education, 29,* 6-9.

Morisky, D. E., & Ward, H. J. (1999). Contrasting approaches and experiences for improving hypertension control among inner city minorities: The Los Angeles program. Paper presented at the meeting of the American Society of Hypertension, New York, NY.

Morisky, D. E., Tiglao, T. V., Sneed, C. D., Tempongko, S. B., Baltazar, J. C., Detels, R., & Stein, J. (1998). The effects of establishment practices, knowledge and attitudes on condom use among Filipina sex workers. *AIDS Care, 10,* 213-220.

Navarro, V. (1997). Race or class versus race and class: Mortality differentials in the United States. In P. R. Lee, & C. L. Estes (Eds.), *The nation's health.* Sudbury, MA: Jones and Barlett, pp. 32-36.

O'Connor, G. T., Quinton, H. B., Traven, N. D., Ramunno, L. D., Dodds, T. A., Marciniak, T. A. & Wennberg, J. E. (1999). Geographic variation in the treatment of acute myocardial infarction: The cooperative cardiovascular project. *Journal of the American Medical Association, 281,* 627-633.

Pappas, G., Queen, S., Hadden, W., & Fisher, G. (1993). The increasing disparity between socioeconomic groups in the United States, 1960-1986. *New England Journal of Medicine, 329,* 103-109.

Perkoff, G., & Anderson, M. (1970). Relationship between demographic characteristics, patient's chief complaint and medical care destination in an emergency room. *Medical Care, 8,* 309-323.

Peterson, M. G. E., Hollenberg, J. P., Szatrowski, T. P., Johanson, N. A., Mancuso, C. A., & Charlson, M. E. (1992). Geographic variations in the rates of elective total hip and knee arthroplasties among Medicare beneficiaries in the United States. *Journal of Bone and Joint Surgery, 74,* 1530-1539.

Poland, B., Coburn, D., Robertson, A., & Eakin, J. (1997). Wealth, equity and health care: A critique of a "population health" perspective on the determinants of health. *Social Science and Medicine, 46,* 785-796.

RAND and Stanford Center for Research in Disease Prevention. (1997). *The California Wellness Foundation violence prevention initiative mid-initiative assessment, vol. 1.* Santa Monica, CA: The RAND Corporation.

Reading, R. (1997). Social disadvantage and infection in childhood. *Sociology of Health and Illness, 19,* 395-414.

Ren, X. S., Amick, B. C., & Williams, D. R. (1999). Racial/ethnic disparities in health: The interplay between discrimination and socioeconomic status. *Ethnic Diseases, 9,* 151-165.

Roberts, L. (1999). Creating a new framework for promoting the health of African-American female adolescents: Beyond risk taking. *Journal of the American Medical Womens Association, 54,* 126-128.

Roe, K. M, Minkler, M., & Saunders, F. F. (1995). Combining research, advocacy, and education: The methods of the grandparent caregiver study. *Health Education Quarterly, 22,* 458-475.

Rundall, T. G., & Phillips, K. A. (1990). Informing and educating the electorate about AIDS. *Medical Care Review, 47,* 3-13.

Russell, K. M. (1997). Public policy analysis of Indiana's minority health initiatives. *Ethnicity and Health, 2,* 105-116.

Sargent, J. D., Brown, M. J., Freeman, J. L., Bailey, A., Goodman, D., & Freeman, D. H., Jr. (1995). Childhood lead poisoning in Massachusetts communities: Its association with sociodemographic and housing characteristics. *American Journal of Public Health, 85,* 528-534.

Schooler, C., Sundar, S. S., & Flora, J. (1996). Effects of the Stanford five-city project media advocacy program. *Health Education Quarterly, 23,* 346-364.

Schulman, K. A., Berlin, J. A., Harless, W., Kerner, J. F., Sistrunk, S., Gersh, B. J., Dube, R., Taleghani, C. K., Burke, J. E., Williams, S., Eisenberg, J. M., & Escarce, J. J. (1999). The effect of race and sex on physicians' recommendations for cardiac catheterization. *New England Journal of Medicine, 340,* 618-626.

Singh, G. K., & Yu, S. M. (1995). Infant mortality in the United States: Trends, differentials, and projections, 1950 through 2010. *American Journal of Public Health, 85,* 957-964.

Smith, G. D. (1996). Income inequality and mortality: Why are they related? *British Medical Journal, 312,* 987-989.

Smith, J. P., & Kington, R. (1997). Demographic and economic correlates of health in old age. *Demography, 34,* 159-170.

Stacey, M., & Olesen, V. (1993). Introduction. *Social Science and Medicine, 36,* 1-4.

Steckler, A., & Dawson, L. (1982). The role of health education in public policy development. Health Education Quarterly, 9, 275-292.

Steckler, A., Dawson, L., Goodman, R. M., & Epstein, N. (1987). Policy advocacy: Three emerging roles for health education. In W. B. Ward, & S. K. Simonds (Eds.),

Advances in health education and promotion, vol. 2. Greenwich, CT: JAI Press, pp. 5-28

Tesh, S. N. (1988). *Hidden arguments: Political ideology and disease prevention policy.* New Brunswick, NJ: Rutgers University Press.

The California Wellness Foundation. (1994). *The California Wellness Foundation violence prevention initiative: A new direction for improving health and well-being in California.* Woodland Hill, CA: Author.

Thomas, S. B. (1990). Community health advocacy for racial and ethnic minorities in the Untied States: Issues and challenges for health education. *Health Education Quarterly, 17,* 13-19.

Turnock, B. T. (1997). *Public health: What it is and how it works.* Rockville, MD: Aspen Publishers.

U.S. Department of Health and Human Services. (1998a). *Closing the gap, healthy people 2010 and beyond.*

U.S. Department of Health and Human Services. (1998b). *Healthy people 2010 objectives: Draft for public comment.* Washington, DC: U. S. Government Printing Office

U.S. Department of Health and Human Services. (1998c). DHHS aims to eliminate racial disparities in health status. *Health Care Financing Review, 20,* 136.

Wallack, L. (1997). Media advocacy: A strategy for empowering people and communities. In M. Minkler (Ed.), *Community organizing & community building for health.* New Brunswick, NJ: Rutgers University Press, pp. 339-352.

Wallack, L., & Dorfman, L. (1996). Media advocacy: A strategy for advancing policy and promoting public health. *Health Education Quarterly, 23,* 293-317.

Wallerstein, N., & Bernstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. *Health Education Quarterly, 15,* 379-394.

Ward, H. J., Morisky, D. E., Lees, N. B., & Fong, R. (in press). A community based approach to hypertension control for an underserved minority population: Design and methods. *American Journal of Hypertension.*

Wilkinson, R. G. (1997). Comment: Income, inequality, and social cohesion. *American Journal of Public Health, 87,* 1504-1506.

Wilson, S. R., Scamagas, P., Grado, J., Norgaard, L., Starr, N. J., Eaton, S. & Pomaville, K. (1998). The Fresno asthma project: A model intervention to control asthma in multiethnic, low-income inner-city communities. *Health Education & Behavior, 25,* 79-98.

Wong, F. Y., Chng, C. L., & Lo, W. (1998). A profile of six community-based HIV prevention programs targeting Asian and Pacific Islander Americans. *AIDS Education and Prevention, 10,* 61-76.

Woodruff, K. (1996). Alcohol advertising and violence against women: A media advocacy case study. *Health Education Quarterly, 23,* 330-345.

Woolander, S., Himmelstein, D., Silber, R., Bader, M., Harnely, M., & Jones, A. (1985). Medicare and mortality: Racial differences in preventable deaths. *International Journal of Health Services, 15,* 1-15.

Yergan, J., Flood, A. B., LoGerfo, J., & Diehr, P. (1987). Relationship between patient race and the intensity of hospital services. *Medical Care, 25,* 592-603.

The Role of Health Education Associations in Advocacy

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Abstract

Over the last 50 years, health professional organizations have assumed more vocal and prominent roles in policy advocacy. An association's political visibility and effectiveness are shaped by its tax-exempt designation by the Internal Revenue Service as well as its budget, location, staffing, organizational structure, communication support, and advocacy priorities. The increased focus of health education organizations on advocacy parallels the profession's evolution toward policy and media advocacy. Today advocacy interventions are considered a vital component of health education programs. Both newly graduated health educators and the current public health education workforce are expected to demonstrate advocacy-related competencies for success in the new millennium. Recent examples of successful advocacy initiatives by health education groups include organizing two Health Education Advocacy Summits and changing federal regulations recognizing health educators as a distinct occupation. While much has been achieved recently through the collaboration of health education organizations, many advocacy-related challenges must be addressed in the 21st century.

The Role of Health Education Professional Associations in Advocacy

Professional societies and associations provide an important function by advancing the knowledge of and providing support for a particular occupation or field of study. Traditionally, many health professional organizations were organized to provide a nexus around scientific research and practice issues of their particular disciplines. In the latter part of this century, however, health professional societies have become more visible and vocal public policy advocates. Unlike the labor movement, which recognized the political advantage of "power in numbers" in the early 1800s, most professional societies were not organized solely to influence legislation. The purpose of this article is to review issues affecting an association's type and scope of advocacy efforts, describe the recent movement of the health education profession toward policy advocacy, provide examples of recent health education advocacy efforts, and suggest future advocacy challenges for the health education profession.

Organizational Considerations in Advocacy

An organization's tax-exempt status from the Internal Revenue Service (IRS) significantly affects the types and level of its political activities. While there are a variety of IRS categories, most health or trade groups have either a 501(c)(3), or 501(c)(6) tax status (Henson, 1996). IRS defines a 501(c)(3) organization as one that is organized and operated exclusively for charitable, religious, education, or safety purposes, or for fostering national or international amateur sports competition, prevention of cruelty to children and animals, or a private foundation (Henson, 1996). The main benefits of 501(c)(3) tax status are that such groups are eligible to receive grants from public and private sources, donations from its contributors are tax-deductible, and the association can apply to receive an exemption from paying state sales tax. Organizations designated as 501(c)(4) are designed for the promotion of social welfare, with their net earnings devoted exclusively to charitable, educational, or recreational purposes. Although contributions to a 501(c)(6) organization is one in which persons or entities have some common business interest, the purpose of which is to promote such common interest and not to engage in a for-profit business. While 501(c)(3) organizations cannot participate directly or indirectly in a campaign for public office, 501(c)(6) groups are not limited in their endorsement of political candidates (Ernstthal & Jones, 1996). Furthermore, a 501(c)(3) organization's political activities must comprise an "unsubstantial" portion of its overall program, which by various inurement tests is considered roughly 20 percent of its total operating budget (Henson, 1996). In contrast, the IRS does not restrict the amount of lobbying by 501(c)(6) organizations, except that its members cannot consider the portion of member dues attributable to lobbying a tax-deductible contribution.

Both 501(c)(3) and 501(c)(6) tax-exempt designations are common among health groups. Many groups that apply for 501(c)(6) status to provide flexibility in their political pursuits also have companion 501(c)(3) foundations to be eligible for the attractive tax-exempt benefits, e.g., the American Dietetic Association and the American Dietetic Association Foundation. Many health-related organizations such as the American Medical Association (AMA) have formed Political Action Committees to enhance their political effec-

tiveness. AMA's political action committee, AMPAC, was formed in 1961, "to advance the goals of medicine at the federal level by supporting candidates who share basic philosophies and similar views on health care issues" (AMA.org). AMPAC is solely supported by voluntary, non-dues contributions by members from the state level up.

In addition to forming PAC's, many of the larger better established health groups operate government relations departments that include registered lobbyists. According to the Lobbying Disclosure Act of 1995, a lobbyist is a person paid by another, whether a client or employer to make lobbying contacts, unless that person spends less than 20 percent of his or her time on lobbying activities for the employer or a particular clients during a six-month period (Ballantine & Ross, 1996). A lobbying contact is an oral or written communication with members of Congress, congressional staff, or political appointees or other senior executive-branch officials regarding federal legislation, federal rules or regulations, the administration of a federal program or policy, or the nomination or confirmation of a person subject confirmation by the Senate. Lobbying activities are broadly defined to include any lobbying contacts with persons covered under the Lobbying Disclosure Act of 1995, as well as any preparation, planning or research, and background work originally intended for use in contacting there persons. If lobbyists make lobbying contacts, they must register under the Act and report information about the contacts to the Internal Revenue Service and information about any lobbying activities. If a person engages in lobbying without contacts, however, no registration or reporting is required (Ballantine & Ross, 1996).

In addition to the legal issues governing the amount of political activity an organization may undertake, many other considerations will affect a group's policy advocacy involvement, such as:

- Budget - Amount of funds committed to advocacy versus other organizational priorities;
- Office Location - Accessibility to policymakers, which may require having a satellite office if the organization is not headquartered in Washington, DC or state local seat of government;
- Staffing - Employing lobbyist(s) or trained government relations staff to maintain ongoing contacts with policymakers and their staffs, monitor legislation and policies, draft positions on proposed legislation based on organizational policy, plan and implement strategies to influence policy, form coalitions, etc.;
- Organizational Structure for Policy Development - Clarifying the role of advocacy within the organization's mission and strategic plan and establishing internal structures committees for developing resolutions or other papers to guide organizational policy;
- Communication Support - Developing a communications plan with members, Congress, the media, and general public to support the advocacy goals; and
- Advocacy Priorities - Identifying what issues are important to the organization's leaders and members and making strategic decisions about which issues to pursue (Golden, 1996).

One of the most difficult but important tasks for any association is establishing priorities among the myriad of important issues related to its mission. To help set priorities, it is vital to conduct an environmental scan on each potential issue that includes information on the: 1) importance of the issue to the organization and its membership; 2) economic, social, environmental health or other impact of the proposed issue; 3) existing science-base supporting the proposed policy or issue; 4) current organizational resolutions or policy statements on the issue; 5) likelihood of being successful at this time on the issue given the current political climate; 6) nature of the opposition to the organization's stance; 7) availability of resources needed for success; and 8) organizational allies on the issue or groups which might be contacted to form coalitions. Although the authority or process for selecting advocacy priorities may vary by association, each group's final list of priorities should be congruent with its mission and strategic plan (Golden, 1996).

The Evolving Role of Advocacy in Health Education

Prior to the social movements affecting the latter part of this century, health professional organizations in general often subsumed an indirect role in policy advocacy, e.g., serving as an information resource for legislators or providing expert testimony. One of the most notable examples was in 1976, when the Society for Public Health Education's (SOPHE) President, Dr. William Griffiths, presented testimony to the President's Committee on Health Education, the Task Force on Health Education, and the Policy Committee of the National Center for Health Education Project (Bloom, 1999). Direct lobbying for political candidates or legislation generally was viewed as a more appropriate role for trade associations, rather than scientific professional groups.

Social movements in the 1960s and 1970s eventually led to enactment of legislation calling for increased direct citizen participation in the decision-making process (Schwartz, Goodman, & Steckler, 1995). By the late 1970s, articles in SOPHE's journal, *Health Education Quarterly*, and other professional publications began to recognize policy advocacy as a form of health promotion and called for increased participation of health educators in the political process. Over the next decade, research in the application of ecological approaches to health education as well as the role of health educators in community coalitions led to further recognition of health educators' roles as policy advocates. Writing about emerging roles for health education in policy advocacy in 1987, Steckler, Dawson, Goodman, & Epstein concluded, "As members of a profession, health educators must actively endeavor to influence those policies that not only determine the kind and amount of resources allocated for health education programs, but also consider the large policy framework under which health education is subsumed" (Steckler & Dawson, 1982. In 1995, a theme issue of *Health Education Quarterly* on "Policy Ad-

vocacy Interventions for Health Promotion and Education", highlighted examples of successful environmental and policy interventions in cardiovascular disease, tobacco control, physical activity, and other program areas (Schwartz, Goodman, & Steckler, (1995).

The essential role of policy interventions in health education programs eventually paved the way for changes in health education professional curriculum and the competencies expected of new health education graduates. *Standards for the Preparation of Graduate-Level Health Educators* enumerated numerous advocacy-related competencies (see Table I) (American Association for Health Education, National Commission for Health Education Credentialling, & Society for Public Health Education, 1999). A report commissioned by the Health Resources and Services Administration, "Health Education in the 21st Century," identified advocacy as one of four critical areas for improving graduate education in the next millennium (Merrill et al., 1998). Policy advocacy is also cited as one of the critical areas for future education and training of the public health education workforce (Allegrante, Moon, Auld & Gebbie, 1999).

Current Advocacy Roles of Health Education Associations

With the increased recognition of advocacy in the profession and practice of health education, today most health education groups include a specific reference to policy involvement in their mission statements or organizational goals. Many groups have offices in or near the nation's capital to facilitate their involvement: American Association for Health Education, Association Public Health Association (APHA, which includes the Public Health Education & Health Promotion Section and the School Health Education and Services Section), Association of State and Territorial Directors of Health Promotion and Public Health Education, SOPHE, and the Society of State Directors of Health, Physical Education and Recreation. Although SOPHE was headquartered for more than 45 years in New York and California, the Society relocated to Washington, DC in 1995 explicitly for the purposes of increasing its policy advocacy efforts (Bloom, 1999). The American School Health Association, based in Kent, Ohio, retains a part-time registered lobbyist to represent its views in Washington, DC.

In addition to organizing individual advocacy efforts, of health education organizations have been working collectively since 1972 as part of the Coalition of National Health Education Organizations (CNHEO) (Table II). The purpose of the CNHEO is to "facilitate national level coordination, collaboration, and communication among member organizations; provide a forum to identify and discuss health education issues, formulate and take action on issues affecting the members' interest; serve as a resource for external agencies; and serve as a focus for the collaborative exploration and resolution of issues pertinent to professional health educators (Coalition of National Health Education Organizations, 1999). Recent examples of political issues that the CNHEO has addressed on behalf of the health education profession include tobacco legislation, Healthy People 2010, proposed regulations for identifying health educators as part of the Standard Occupational Classification (SOC) used by the Departments of Labor and Commerce.

All CNHEO members have advocacy committees or mechanisms in place for issuing action alerts to their leadership and members as well as resolution processes to form the basis for their political positions. The availability of electronic communications, including websites and listserves, has greatly enhanced the timeliness of groups' political responsiveness and helped ease financial barriers of advocacy-focused communications programs. Advocacy priorities span the broad range of issues from funding of research in the behavioral and social sciences, to education/training of future health educators, to appropriations of major health programs (e.g., Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health).

In 1995, the CNHEO and the National Commission for Health Education Credentialing, Inc. sponsored an invitational meeting in Atlanta, "The Health Education Profession in the Twenty-First Century: Setting the Stage" to address the future of the health education profession (National Commission for Health Education Credentialing, Inc., & Coalition of National Health Education Organizations, 1995). Advocacy emerged as one of six priority areas, with participants identifying 15 actions needed with the profession and 14 actions needed external to the profession to move it into a significant role within the United States (See Table III). Many of these advocacy goals are being addressed, in part, through sponsorship of an annual Health Education Advocacy Summit.

The First and Second Annual Health Education Advocacy Summits were conducted during the spring of 1998 and 1999. The Summits provided health education organizations the opportunity to come together for the first time to develop a common advocacy agenda and to collectively advocate for these issues on Capitol Hill. They also provided the catalyst for participating groups to subsequently provide training, materials, and other resources to their leaderships, members, and chapters on key health education issues. This has been accomplished through special sessions of the groups' annual meetings, newsletter articles, web pages, and targeted mailings. Particularly exciting is the role of students and new professionals from Eta Sigma Gamma in the Summit and in encouraging grass roots follow-up through its chapters. The Summit provides the students an opportunity to "practice what is preached" in the classroom.

Support for the Summit grew from 1998 to 1999, both financially and in terms of the number of participating organizations and appears to be gaining momentum for future years as an ongoing mechanism for the profession's advocacy goals. The Summits also have helped forge new part

nerships and coalitions with organizations such as the National Education Association, Effective National Action for Control of Tobacco, the Campaign for Tobacco-Free Kids, and the Centers for Disease Control and Prevention Coalition. Planning is now underway for the third Health Education Advocacy Summit in March, 2000.

Health education organizations have also made significant progress in recent years in terms of developing external systems to influence public policy and affecting policy changes in support of health education. Almost all groups have had input into broad policy-related documents such as the proposed "Healthy People 2010 Objectives," which, in part, provide the basis for policy and resource allocation at the state and local levels. In 1997-98, SOPHE spearheaded an effort involving the CNHEO to obtain recognition by the Departments of Labor and Commerce for the distinct occupational classification of "health educator," which was a major victory (Auld, 1997). For the first time, the federal government and states will begin gathering data about the geographic distribution, salaries, and other essential data for the profession. In addition, ASTDHPPHE, SOPHE, and SSDHPER are collaborating on a Public Health Education Leadership Institute, a year-long program to develop leadership skills of their members (Capwell, 1998).

Future Challenges

Although health education organizations have made significant advocacy strides in recent years, many challenges are ahead for the 21st century. First, health education groups must have a sustained presence on Capitol Hill, not just a barrage of visits once per year. Relationships built during the Summits with Congressional representatives and their staffs must be sustained for long-term political impact. Second, the groups need to narrow and better focus their annual political objectives. Although there are many worthwhile public health issues, taking on too many complex and difficult issues only decreases the likelihood of political victory on any one of them. Third, health education associations need to expand ways of effectively mobilizing their memberships "outside the beltway" (including chapters, regional groups, and districts) and continue developing their advocacy skills. Likewise, such groups must encourage members to run for leadership positions or political offices at the local, state, or national levels. Currently, a formally trained health educator, Robert Patton, is serving his second term in the Tennessee legislature. Fourth, health education groups must continue advocating for funds to expand the research base of the health education discipline. A richer science-base on the effectiveness of health education interventions will, in turn, strengthen our arguments for health education programs in Congress. Finally, because the occupation of health educator and the issues important to the profession are still relatively obscure to policymakers, health education organizations must make a long-term commitment to advocacy. They must budget the financial and human capital to maximize the effectiveness of their advocacy efforts, while still acting within IRS restrictions of their tax-exempt status.

References

Allegrante JP, Moon R, Auld ME & Gebbie K: Future training needs of the public health education workforce. Submitted for publication to *Health Promotion Practice*, 1999.

American Association for Health Education, National Commission for Health Education, and Society for Public Health Education: A Competency-Based Framework for Graduate-Level Health Educators, 1999.

American Medical Association (1999). Retrieved from http://www.ama.org September 30, 1999.

Auld, E: (1997). SOC approves new occupational category for "Health Educator." *The CHES Bulletin, 8*, 61-62.

Ballantine, R., & Ross, J.L. (1996, February).*Government relations newsletter.* American Society of Association Executives.

Bloom, F. K. (1999). *The Society for public health education: Its development and contributions, 1976-1996.* Doctoral Dissertation. UMI Dissertation Services, 88-379.

Capwell, E. (1998). Public Health Education Leadership Institute. *News & Views, 25*(2), 5.

Coalition of National Health Education Organizations Retrieved from http://www.MED.USF.EDU/~KMBROWN/CNHEO.HTMSeptember 30, 1999.

Ernstthal, H.L., & Jones, B. (1996) *Principles of association management. (3rd ed.).* Washington, DC: American Society of Association Executives.

Golden, M. (1996).*Government relations in the association environment.* Presented at the American Society of Association Executives School of Association Manage ment: Government Relations, June 4-5, 1996, Washington, DC.

Henson, J.A. (1996). *The ABC's of non-profit status.* Society for Public Health Education Annual Meeting, November 15-17, 1996, New York, NY.

Merrill R, Chen DW, Gielen A, McDonald E, Auld ME, Mulrooney SJ, Sampson NH: The future health education workforce. Journal of Health Education 29(5):S59-S64, 1998

National Commission for Health Education Credentialing, Inc. and Coalition of National Health Education Organizations: The health education profession in the twenty-first century: Setting the stage. *Journal of Health Education 27*(6),357-364, 1996.

Schwartz, R., Goodman, R., & Steckler, A. (1995). Policy advocacy interventions for health promotion and education: Advancing the state of practice. Health Education Quarterly, 22(4),421-527.

Steckler, A. & Dawson, L., (1982). The role of health education in public policy development. *Health Education Quarterly, 9*(4), 275-292.

Vernick, J.S. (1999). Lobbying and advocacy for the poblic's health: What are the limits for nonprofit organizations? *American Journal of Public Health 89*(89), 1425-1429.

What Legislators Need from Their Constituents Regarding Advocacy Efforts: A View from the Inside

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If a tree falls in a forest, does it make a sound? This question has been debated for years in philosophy classes across America. Perhaps the true answer is that nobody really cares. The same answer may hold true for those U.S. citizens who want to have their voices heard; however, do not find it necessary to vote. The simple reality is that those who do not vote have a difficult time justifying their causes. Their messages carry little weight. A person who is a voter, however, and who is determined to make a difference, can be heard. Voters who spearhead advocacy efforts can be effective if they become fully aware of what legislators need from constituents. Therefore, in order for advocates to bypass unnecessary pitfalls and to make a true impact, they must follow two basic rules: do the necessary homework and plan ahead.

Do the Necessary Homework

As Executive Director of the Pennsylvania House of Representatives Majority Policy Committee, I have witnessed a number of effective advocacy efforts that have made an impact on legislation and policy formation. In the vast majority of cases, however, the good intentions of those intercessors were ignored because they simply were not fully informed about the issue for which they were fighting. Advocates must understand the history of an issue and be fully aware of political and public perception regarding the issue. In addition, advocates should be able to explain how other legislators and legislative bodies have acted on the issue in the past. Additionally, advocates only waste time if they simply complain about the problem to their legislator. Instead, they should be professional and concise. They should also base their solutions on political realities rather than on "pie in the sky" dreams. Only advocates with a focused message will rise above the rest and make a significant difference. Legislators are bombarded with a vast amount of information daily. Advocates must be prepared to be concise and informative when presenting the issue at hand. Otherwise, their concerns regarding a particular issue may go unnoticed, or be given only minimal credibility.

In addition to being thorough, advocates must be fully aware of how a legislator's constituency feels about the issue at hand and the likelihood that proposed legislation will be enacted. A legislator may not be able to support an advocate's efforts if the issue has little chance of passing or if the public views it in a negative light. This is the simple reality because elected officials are acutely in-tune with the public's wants and needs, especially of those wants and needs of the voters within their constituency. For example, health issues are currently on the minds of the public. Therefore, an advocate of any health-related issue operates with a distinct advantage in being given a forum with a legislator.

Advocates must distinguish between the voters and the general public because, in reality, legislators serve the voters. The actions of legislators are based on this fundamental premise. As a result, legislators make an ongoing effort to determine exactly what voters want. Effective advocates must understand this concept and tailor their messages in a way that presents a "win-win" scenario to the legislator. In other words, the advocate must say, "This is the issue I am advocating. This is what your opponent thinks; however, the people in your district and across the country want this. A large percentage of voters in your legislative district feel this way. You should too. If you make this part of your platform, we will both win." The presentation of a "win-win" situation often works, because, after legislators determine or are made aware of how voters feel about a particular issue, they are held accountable to their employers, the voting public.

Advocates who educate themselves about how a legislature's constituency feels often actually provide the legislature with a service. Legislators need the benefit of effective advocacy to supply them with insight into the voters' perspectives about certain issues. In addition, advocates who present a legislator with such information exercise constitutional freedom and assure that government is acting for the people.

Advocates should also research the legislator's background in at least four distinct areas. First, advocates must determine whether a legislator is a "freshman" or a "seasoned" legislator. Freshman legislators may still be a little tentative, simply because they lack seniority and experience. Seasoned legislators, on the other hand, may be nearing the end of

their legislative careers, and feel the need to do something dramatic for their political party.

Second, advocates must know a legislator's internal position within his or her caucus. Advocates need to ascertain whether or not a legislator is in a "swing district." In some instances, legislators have a great deal of power and control in swing districts. This occurs when the balance of power in a district can literally swing in either the Democrat or Republican Party's favor. Consequently, a swing district legislator may influence a particular party and determine which party controls a legislative body.

Third, advocates must become aware of a legislator's past and personal life. For example, if the legislator had been a physician or a nurse before entering into politics, approaching him or her about health care issues may be more beneficial to an advocate than approaching a legislator who has no medical background. By exploring a legislator's background, an advocate may determine that a legislator has children; therefore, issues concerning children may be near and dear to that person's heart.

Finally, advocates should determine on which committees a legislator serves. Service on a particular committee may influence a legislator's views, and those influences may aid advocates in their cause. Committee membership can play a huge role for legislators, and for advocates in their constituencies, regarding issues that are under their legislative committee jurisdiction.

Plan Ahead

Whether it is a trip to the beach with the family or a speech in front of a crowded room of colleagues, in order for these events and all events in life to be successful, common knowledge tells us that a plan of action is always needed. As an attorney, as the Executive Director of the Pennsylvania House of Representatives Majority Policy Committee, and as a human being, I have always found that it is necessary to plan ahead.

It is no different in this case. Advocates planning to have their voices heard should plan to communicate a solution to the legislator in a way that the legislator can pass it on to his or her constituents. Advocates can do this by defining their message in a way that is palatable to the legislator and to the public. For example, one issue that is a continuing presence in the Pennsylvania Legislature is School Vouchers. As the old maxim goes, "it's all in the presentation." One message an advocate could communicate about School Vouchers is to say, "Public school teachers and their unions are not doing a good job educating our children." A second, and more acceptable message, would be, "We want to give students a chance and parents a choice." The second message presents legislators with an effective way for them to communicate the message to voters. Regardless of the issue at hand, advocates should plan to meet with the legislators or a member from the legislators' staff, and plan long-term, working relationships.

Advocates should also plan to make every effort to personally meet with legislators, either in their district or capitol office. Often times, these types of meetings are difficult to arrange, simply because the extreme demands and time constraints placed on legislators make meeting with advocates logistically impossible. Advocates should take advantage of any opportunity to meet with someone on a legislator's staff. An "all or nothing" attitude on the part of an advocate will not advance any cause. Even a nibble from the legislator or a member of his or her staff might turn into an entire meal later. Perhaps a rule of thumb for advocates is to settle for less than they had originally planned and always ask for more than they need.

During meetings with legislators or their staff, advocates should plan to take ample notes. In addition, after the initial meeting, advocates should follow up with a telephone call and a letter reiterating what was discussed and what the legislator or legislator's staff promised. Such communication will help establish the desired strong working relationship.

Another type of working relationship advocates should seek is to build alliances with other people or groups who are advocating the same or similar positions on local, state, or federal levels. The synergy that is created by alliances dramatically increases the impact of the message on a legislator or a legislative body.

As Ralph Waldo Emerson once wrote, "Nothing is at last sacred but the integrity of your own mind." This means people can have a great deal of self-respect if they fight for what is right–if they want to have their voices heard. Those who desire to be heard–to be advocates–must set their own standards; however, doing the necessary homework and planning ahead will help their voices to be heard by those whose attention they seek. In my experience with the Pennsylvania House of Representatives, I have found that only those who truly put forth the effort required to do their homework and plan their communications have voices loud enough to be heard and to make a difference. For those voters who are interested in what legislators need from constituents, following these suggestions regarding advocacy efforts does not ensure that every advocate's voice will always be heard; however, these tips may help truly committed advocates to achieve their goals.

Youth Advocacy: The Florida Tobacco Prevention Model

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NB: The Authors would like to recognize the contribution of Merlyn Smart to the development of this paper. Ms. Smart has a masters degree in Health Education and is currently a PhD student in the Educational Research Department of the College of Education at Florida State University.

Through the Florida Tobacco Pilot Program, in an attempt to create an awareness of the dangers associated with tobacco and tobacco products, the state of Florida embarked on a statewide plan of action. Throughout Florida, a major concern regarding the health of youth has led to the initiation of the Florida Tobacco Pilot Program. The extent of tobacco addiction among youth, and the effects of these products on the health of youth, have been ignored and replaced by advertisements that have all glamorized tobacco and tobacco products.

The initially coordinated efforts against tobacco in Florida under the aegis of the Tobacco Free Coalition were founded in 1993. These efforts were further boosted in 1994, with the receipt of one of nine states' grants offered by the Robert Wood Johnson Foundation for Smokeless States. This grant was helpful toward the formation of 25 county coalitions. In August 1997, the late Governor of the State of Florida, Governor Lawton Chiles, was victorious in his negotiation in the war against the tobacco industry. This victory resulted in a landmark settlement of $11.3 billion with the tobacco industry. This agreement was representative of the Governor's relentless advocacy for the health of children. The settlement also included the most stringent prohibitions ever imposed on any agency concerned with advertising and marketing to youth. Of the monetary concession allotted, two hundred million dollars were earmarked to fund a pilot program. The primary goal of this effort was to attempt to reduce tobacco use among children and adolescents.

Adults have for years come together to determine what problems exist within the community that put our youth at risk for poor health development. We have also for years come together as adults to determine what the best course of action to correct the existing problems. Finally, when we have determined what is wrong in the community and what will put it right, we have come together to determine an implementation plan to assure proper execution of our plan. Responding to the plain need to address these trends, government at all levels has mounted efforts over the past 30 years to deal more constructively with issues of youth development, family and education. For a number of reasons, these initiatives have enjoyed limited success:

*First, ideological differences over value-laden aspects of youth development, such as character education, moral training and sex education, keep people apart...

*Second, traditional intervention schemes fail to acknowledge the inter-related problems of youth and families....

*Third, the community-based collaborative initiatives that have sprung up in the vacuum of governmental inaction have, themselves, failed to generate more than superficial, publicity-oriented results. (Hancock, 1994, p. 139).

With this observation as a backdrop, Florida's governor Lawton Chiles directed that the Florida Tobacco Pilot Project be conducted in a way that guaranteed the active and meaningful participation of youth and that all programs have a youth orientation. The role of adults was largely to facilitate youth and to develop and implement programs developed and approved by youth. The structure that allowed this process to be implemented was through a youth board of directors that represent a variety of constituencies throughout the state. This board of directors meets on a regular basis to establish priorities for Florida's fight against youthful tobacco use. The establishment of SWAT (Students Working Against Tobacco) provided the field troops for this war on tobacco use by youth. SWAT established a number of program initiatives, the most prominent being the advertising blitz against tobacco use by adolescents. The evaluation component of the Tobacco Pilot Program at the University of Miami determined that the overall impact of SWAT's media campaign against tobacco resulted in a 17% decline in tobacco use in a one-year period. This represented a decline in tobacco use that was unprecedented in the 30 years since the original report of the Surgeon General's Advisory Committee on Smoking and Health (Luther L. Terry, M.D., 1964), until the 1994 report on preventing smoking among young people (U.S. Department of Health and Human Services, 1994) on smoking and health. Compared to the findings in Doi and DiLorenzo's study, (1993), the Florida Tobacco Pilot Program results are again outstanding. "Initiatives focused primarily on youth are caught up in the politics of advocacy groups that polarize issues and divide communities. The result is either grid lock, where interest groups

block responsible action, or weak initiatives rendered unsustainable by lack of broad community commitment; such projects are killed as political majorities in legislatures shift and constituencies for urban action lose power...." (Hancock, 1994, pp. 140-141)

The Tobacco Industry settlement has resulted in many states throughout the country initiating programs aimed at either the prevention of tobacco use among youth, or at the cessation of smoking among young people. Examples can be identified in which the states have begun efforts that help to empower youth in their battle against "Big Tobacco."

In Minnesota

· "Senate Majority Leader Roger Moe's (D) proposal calls for a $655 million trust fund aimed at **preventing young people from smoking."** (Minneapolis Star-Tribune, January 21, 1999) **INCLUDE in Reference**

In Missouri

· "I ask you to establish a Tobacco Settlement Trust Fund.... Its purpose will be to preserve these funds for future investment **to support anti-teen smoking initiatives** and to improve...." (Governor Mel Carnahan [D], State of the States Address, January 20, 1999)

In Washington

· "The Governor also proposed using the tobacco settlement to establish a $150 million endowment fund to supplement intensifying national efforts to help smokers quit and **convince young people not to use tobacco**." (Press Release from Governor Gary Locke [D], December 2, 1998)

Compared with these stated efforts, Florida's anti-tobacco initiatives seem to be directly focused, in that Florida's anti-tobacco efforts have pivoted around the goals as identified by the Florida Tobacco Pilot Program. One such goal is to empower youth to lead community involvement against tobacco. Organizations and institutions working cooperatively with the Florida Tobacco Pilot Program have set this goal as a priority in their respective communities. The Florida Tobacco Pilot Program has used youth advocacy training to effectively accomplish the priority of empowering youth. This training has been addressed mainly through three of its five components:

· Education and Training
· Youth Programming & Community Partnerships
· Marketing & Communications

With the help of varied agencies and organizations and through these components, the Florida Tobacco Pilot Program has concentrated its efforts on promoting youth advocacy in order to heighten youth awareness of the role they could perform in changing public policy. Through planned activities and hands-on experiences provided by these organizations, the Florida Tobacco Pilot Program has been able to encourage activism among teens in their anti-tobacco combat. Many organizations and agencies have been instrumental in assisting to host Summit Conferences, at which teens have received training in several relevant areas.

With emphasis on youth, during the two-years of the Florida Tobacco Pilot Program, planners have organized many youth-related activities. From these activities the youth of Florida have gained a diversity of experiences. These activities have also given rise to permanently formed groups, and through these groups, the trainers within the Florida Tobacco Pilot Program deliver training programs and experiences that are required to empower the teens to be successful against "Big Tobacco."

Students Working Against Tobacco (SWAT) has been one of the primary groups formed. Through the formation of this group, the young people of Florida have been empowered to engage in struggles that protect their generation from the dangers of tobacco. With their motto: "Defenders of a generation," SWAT members have been delivering powerful messages to their peers about their rebellion against "Big Tobacco's" manipulation of youth. The existence of the SWAT group has given teens the opportunity to provide leadership and direction. Having representatives from all 67 counties within the State of Florida has facilitated communication for planning their advocacy activities and for working with adult members. The formation of the SWAT group has proven to be a catalyst in the Florida Tobacco Control's efforts at achieving the goal of empowering the youth. The working relationship between youth and adults has provided support for teens, as well as examples of effective and efficient management. Representatives of SWAT have been provided with the skills that they could confidently use in formulating policy and implementing new programs in their communities. SWAT is youth-led and youth-directed in its anti-tobacco initiatives. It is, therefore, easier for the teens to disseminate the messages that they have created, and to successfully reach their peers.

Through the executive leaders and coordinators of SWAT, both the youth and adult population throughout Florida are constantly made aware of the nature and purpose of their anti-tobacco campaign. Through the development of relationships with various organizations within their communities, SWAT members and coordinators have been able to incorporate members from multicultural clubs and minority sports organizations who share similar concerns.

Teen Summit 1 and 2 have been two intensive training programs that were planned for teens by the Florida Tobacco Pilot Program. The first Summit helped to empower the teens to develop programs. It was at this conference that the teens were given the opportunity to develop a program of training, and to give a name to the group by which they now operate. The second Summit provided the opportunity for the teen leaders to hold rallies, and to enable the participants to attend sessions that could assist them in becoming more pow-

erful advocates. At this Summit, equipped with their Truth Campaign, the teens at Summit 2 were aware that the main goal was to inform and empower. The planners, on the other hand, had as their main objective, that of providing youth with the training necessary to initiate advocacy activities in their communities.

The sessions at the second Summit were designed to equip the teens with the skills necessary for:

1. fighting tobacco advertisement,
2. developing a local smoke-free dining guide for restaurants in their neighborhoods, and
3. communicating before the legislature about the prevalence of teen tobacco use.

Emphasis during Summit 2 was placed on youth advocacy. The presenters, therefore, engaged the teens in simulative activities that enabled them to experience the success that is necessary to build confidence and develop leadership skills. This focus on advocacy has helped to develop a heightened awareness that could motivate teens into accomplishing the mission of SWAT. Subsequently, the teens have had the opportunity to implement some of these programs in several counties throughout the state, using the skills with which they have been equipped.

A great part of the youth training planned by the Florida Tobacco Pilot Program has also included media training. In the media training sessions, the teens are provided with experiences to enable them to excel at media communications. The teens have, therefore, been given the opportunity to prepare and deliver messages using different types of media. These training sessions have been planned to empower the youth to develop their own capabilities of persuasion and enhance their ability at helping to convince others of their own opinion. These authentic experiences to which the teens have been exposed have helped them to realize the effects that media advertising can have on popular opinion. In turn, they develop greater awareness that tobacco advertisements they view are only a means of manipulation and deception by the industries involved.

Community Partnerships represents another contribution to the youth tobacco prevention and cessation campaign within Florida. In these initiated programs and activities, young people have been empowered to work with their peers and adults at school and community levels within the state. Thus, the role of the youth who participate in these activities is to persuade other teens to reject being targets of manipulation from tobacco advertising messages and to resist pressures from peers who try to encourage them to use tobacco.

Training sessions have been used to provide the tools and skills that teens would need to change public policies in their own communities. The teens have been allowed to participate in activities that involve procedures related to county, city, and other legislative procedures. Through different types of media, teens practiced reversing the process of manipulation. In addition, from training in hands-on art classes, teens have been shown that art can play a major role in the manipulation of public opinion. Teens have become greatly aware of how to make art influence social values in a positive or negative way.

School-Based Tobacco Education has provided teens of school age with information about tobacco. The knowledge with which students have been provided through these programs represents great power for the teens. Providing this information about tobacco to teens can heighten their awareness about making life decisions. In addition, this knowledge provides teens with the support they need to make decisions within their peer-group environment, and to buffet social pressures they might encounter. The planners of the Florida Tobacco Pilot Program's campaign have realized that it is necessary that teens know all the facts related to tobacco. They have therefore made these facts available, in order to empower youth to make independent and appropriate choices with respect to tobacco use.

Providing basic knowledge about tobacco and tobacco products could prove to be quite powerful. Even greater power is given to the teens when they are provided with knowledge about the laws concerning tobacco possession and the dangers of its use. The Florida Tobacco Pilot Program, through its School-based Tobacco Education programs, has been able to provide the required information, thus keeping a great percentage of the youth in the State of Florida safe, by attempting to turn them away from tobacco. These programs have also helped to empower the youth through development of character via moral and ethical education. With the training provided, students are also empowered to act as guides and mentors to educate their peers about the consequences related to violating the State's laws related to minors.

SQUADS (Study, Question, Understand, Act, Debrief, Success) is yet another curriculum-focused effort of the Florida Tobacco Pilot Program. This program has been similarly developed to provide youth with the power of knowledge about tobacco and tobacco use. SQUADS is a youth-led tobacco control action program. Teens are empowered to create community service projects for which they may provide leadership. These efforts enable teens to focus on their own concerns about local control issues. This effort has been initiated in St. Lucie County where a group of adults had been identified to serve as advisors and facilitators to the teens. The facilitators / advisors guide the youth into obtaining appropriate resources necessary for successfully implementing youth-led anti-tobacco efforts. The Florida Tobacco Pilot Program views SQUADS as an appropriate training program that could empower youth with the ability to build relationships with community leaders and effectively communicate through the media their various concerns about tobacco control issues.

Virtual You is a part of the content sector included among the Florida Tobacco Control's multidisciplinary, multi-sensory, science resource materials provided at the website Sci-

ence, Tobacco & You. This Science, Tobacco & You project is a creation of the Center for integrating Research and Learning at the National High Magnetic Field Laboratory at Florida State University. As part of its innovative efforts, Science, Tobacco & You has created the Virtual Town Hall, which provides students with experiences comparable to the Sunshine State Standards. The Sunshine State Standards are a collection of concepts, arranged by content area, which students are expected to know and understand as they progress through school. The Standards are only guidelines that tell teachers and parents what the students are expected to know.

The Virtual You experience empowers youth to learn about the effects that tobacco use could have on the body over a period of time, through the creation of a *virtual self*. The student is able to create the self, operate an MRI system, and view images of the lung as affected by tobacco use. On his or her own, the student is also able to image vital organs and independently observe the effects that could result from the use of tobacco.

Virtual Lab is another component of the Virtual Town Hall. In this laboratory students have the opportunity to explore the hands-on activities that they conduct during sessions using the laboratory manipulative package and guidebooks that are provided. The experiences that they obtain in the laboratory using data collected in their class sessions enable the students to directly observe and explore changes in physical ability as a result of smoking. In these sessions students have the opportunity of independently learning about the dangers of tobacco use.

Other curriculum-based programs have been developed through the Florida Tobacco Pilot Program to assist in helping to empower the youth. The **N-O-T (Not-On-Tobacco)** is a program developed through contract with the American Lung Association of Florida and the Office of Tobacco Control. **N-O-T** represents a teen tobacco cessation program developed by the Prevention Research Center of West Virginia University and provided by the American Lung Association. The sessions provided are designed to assist the youth in developing or increasing life-management skills.

Also included among the empowerment efforts of the Florida Tobacco Pilot Program, are the **Life Skills Training** programs. These programs address the needs of middle and high school students in identifying the primary causes of substance abuse. The sessions also afford teens the opportunity to learn a combination of personal self-management and social skills. The experiences also help to develop, to a high level, the overall personal competence of the teens, thus decreasing their vulnerability to tobacco use.

Towards No Tobacco (TNT) is a project of the Florida Tobacco Pilot Program. This project has been developed on the premise that youth are best able to resist tobacco when they have been empowered with the basic knowledge of the product, provided with skills to overcome social pressures to use tobacco, and, are made fully aware of the consequences of tobacco use. The Florida Tobacco Pilot Program has designed the sessions so that the curriculum is administered over a two-week period. The focus of these sessions has been on improving listening skills, on building self-esteem and assertiveness, and on counteracting the persuasion that could occur through media and social influences.

In addition to the teaching-learning experiences aimed at empowering youth, the Florida Tobacco Pilot Program has designed **Retailer Compliance** investigations. These activities have been designed such that, contracting agencies recruit young people to assist in investigations. In these instances, the youth volunteer, under police supervision is empowered to enter a retail tobacco dealer's premises to act as a target, and to assist in apprehending the dealer if he or she is found attempting to retail tobacco products to the minor.

Conclusion

Based on views expressed by evaluators of existing tobacco prevention programs, there are some principles that guide the development of any successful program to prevent and reduce tobacco use. Among the guiding principles provided, is the necessity of the program to address high-risk and diverse populations.

In order to meet the needs of these special populations, the planners and trainers with the Florida Tobacco Pilot Program have designed and disseminated anti-tobacco information in ways they hope will empower youth. To achieve this objective, the trainers have concentrated most of their efforts on youth advocacy training programs.

Early in this paper a reference was made to the Florida Tobacco Pilot Program. Through its many carefully planned and well-implemented anti-tobacco initiatives, the program has attempted to make an impact on as many segments of its diverse population as possible through its main agency, SWAT (Students Working Against Tobacco). Using the concept of empowerment as the principal strategy, agencies, organizations, and individuals, continue to work with teens throughout the State of Florida to ensure that they develop the leadership and management skills needed to work as effective advocates against the manipulation of "Big Tobacco."

References

Doi, S. C., & DiLorenzo, T. M. (1993). An evaluation of a tobacco use education-prevention program: A pilot study. *Journal of Substance Abuse, 5*(1), 629-642.

Hancock, M., (1994). Collaboration for youth development: Youth action programming. *National Civic Review, 83*(2), 139-146.

U.S. Department of Health and Human Services. Preventing Tobacco Use among Young People: A Report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1994.

Advocacy Issues Among American Indians

Linda Bane Frizzell, Ph.D.

Federally recognized American Indian tribes and Alaska Natives (AI/AN) have a unique relationship with the United States of America. The provision of health services for AI/AN occurs through a government to government arrangement. The statutory foundations for health care and related health services for AI/AN are found in the following documents: Commerce Clause of the *U.S. Constitution*; the *Snyder Act* of 1921; the *Transfer Act* of August 5, 1954; P.L. 93-638, the *Indian Self-Determination Act*, with subsequent amendments; and the *Indian Health Care Improvement Act*, P.L. 94-437, with subsequent amendments as a basis for maintaining and fulfilling trust, legal, and moral responsibilities of the federal government. It is this government to government relationship that is critical for the current 584 federally recognized tribal governments to advocate for their members.

Additionally, some tribal governments are not federally recognized, but do have recognition by their respective state governments. There are still others that are struggling to regain any governmental recognition. As these tribes win their legal battles to regain federal recognition, their ability to advocate for their constituents greatly improves.

There are several national member organizations that provide a variety of advocacy roles for health care and related services. Information about the National Congress of American Indians, the National Indian Health Board, the National Indian Council on Aging, and the National Council of Urban Indian Health are listed below:

The National Congress of American Indians (NCAI), which was founded in 1944, is the oldest, largest, and most representative national Indian organization devoted to promoting and protecting the rights and interests of tribal governments. The founding members of NCAI stressed the need for unity and cooperation among Indian governments and people, for the security and protection of treaty and sovereign rights, and for the betterment of the quality of life for Indian people. NCAI has become the leading Indian membership organization, serving a diverse network of nations with a combined citizenry comprising more than three quarters of the American Indian and Alaska Native national population (www.ncai.org., 1999).

The National Indian Health Board (NIHB) represents Tribal Governments that operate their own health care delivery systems through contracting and compacting, as well as those that receive health care directly from the Indian Health Service. NIHB is a non-profit organization that conducts research, policy analysis, program assessment and development, national and regional meeting planning, project management, and training and technical assistance programs. These services are provided to Tribes, Area Health Boards, Tribal organizations, Federal agencies, and private foundations (www.nihb.org., 1999).

The National Indian Council on Aging (NICOA) has a mission "to bring improved, comprehensive services to American Indian and Alaska Native elders." The organizational objectives are communication and cooperation with service provider agencies and aging advocacy organizations, dissemination of information about available resources to the national Indian community, intercessions with appropriate agencies to ensure that elders have access to these resources, provision of information and expert testimony requested by Congress, and serving as a national clearinghouse for issues affecting Indian elders (www.nicoa.org., 1999).

The National Council of Urban Indian Health (NCUIH) organization provides national leadership services for the over 55 Urban Indian Health Program Branch (UIHPB) programs across the country. "Founded in 1994, NCUIH is the only membership organization of Urban Indiana Health Programs, providing advocacy, expanding resources, and creating a "national voice" for Native American/Alaska natives living off reservation. Approximately 60% of Native American/Alaska Natives live off reservations in the United States, approximately 53% of those in urban centers of cities. NCUIH, created by and for Urban Native people, addresses the changing needs, health and general welfare of Indians through advocacy and education" (www.his.gov/nonmedicalprograms/urban/ncuih/home.html, 1999).

The Indian Health Service (IHS) is the principle federal agency that advocates for American Indian health services. The mission of the IHS is to provide a comprehensive health services delivery system for American Indians and Alaska Natives with opportunity for maximum Tribal involvement in developing and managing programs to meet their health needs (U.S Department of Health and Human Services, 1997).

The *Indian Health Care Improvement Act (P.L. 94-437)* mentioned previously is due for reauthorization in the year 2000. Tribes from across the country organized into a representative *National 437 Steering Committee* to engage in a formal consultation process. The participants included

elected tribal leaders, tribal representatives, the IHS, urban Indian programs, the Department of Health and Human Services (specifically, the Health Care Financing Administration), and congressional staff.

This is the first time that tribes from across the country have come together to advocate for their health concerns in concert to develop amendments to *P. L. 94-437* in a consensus document. This consultation process started with each of the twelve IHS geographic areas sponsoring meetings to gather concerns from providers, patients, and local leaders.

The next step was four regional consultation meetings, during which recommendations were shared, and a consensus-building process was developed among participants in order to carry forward a unified position for each recommendation. Upon completion of the four regional meetings, the *National Steering Committee*, comprised of two representatives from each IHS geographic area, began their duties to place the recommendations into legislative bill language for further comment by all the tribes across the country. (At the time of this publication the consultation process has been completed and draft language has been approved by the *National Steering Committee*. Additionally, comments from tribes across the country have been considered and documented for inclusion in the final document.) The entire process was not only very time consuming, but also clearly demonstrated that tribal governments are determined to improve their ability to provide health services and programs for all Indian people across the country.

There are many issues for advocacy for American Indians. Perhaps the next section of this document will help to explain why tribal governments are looking past their own histories of wars against each other to unite in one voice to improve the health status of all Indian people.

The basis for this advocacy starts as historical mistreatment and oppression. In the 500 years since the arrival of non-native people to the Americas, the indigenous people have experienced:

- genocide,
- sweeping epidemics,
- forced acculturation,
- forced assimilation,
- involuntary relocation and displacement,
- missionary conquests,
- lack of understanding and acceptance of Traditional Healing,
- oppression of spiritual beliefs, and
- swindled or forced forfeiture of land.

These atrocities are far reaching and remain as the major contributing factors for an entire race of people who have the poorest health status of any population in the United States.

In Fiscal Year 1996, the IHS service population was approximately 1.41 million people. This service population has been increasing at a rate of 2.2 percent per year (U.S. Department of Health and Human Services [USDHHS], 1995). The Indian population is younger, less educated, and poorer than the United States All Races population (Regional Differences in Indian Health, 1997).

One reason for the youthfulness of the Indian population is the large proportion who die before age 45. Most of the excess deaths, those that would not have occurred if Indian death rates were comparable to those of the total population, can be traced to six causes: unintentional injuries, cirrhosis, homicide, suicide, pneumonia, and complications of diabetes (U.S. Department of Health and Human Services & Public Health Service, 1991).

Diseases and causes of death among Indians in reservation States today are different from those prevalent two generations ago. Cardiovascular disease has become the leading cause of death for Native Americans (Galloway, Goldberg, & Alpert, 1989). The increase of deaths due to cardiovascular disease can be attributed to high fat diets, increasing rates of smoking, and increasing rates of Type II diabetes.

Cancer incidence and mortality have demonstrated steady increases among American Indians and Alaska Natives during a relatively limited time frame, as well as unique patterns of site-specific cancers (Mahoney & Michalek, 1999). Additionally, the cancer-survival data reveal that AI/AN have the poorest survival of any racial group for all types of cancer.

A comparison of the age-adjusted mortality rates for American Indians from 1992 to 1997 is alarming at best. Figure 1 depicts the differences between age-adjusted mortality rates for American Indians and those for the general American public. Although the 1992 rates are appalling in and of themselves, the 1997 rates show increases in five of the seven categories listed.

Figure 1

1992 and 1997Age-Adjusted Mortality Rates for American Indians in Relation to Population at Large

	1992	1997	Net Change
Tuberculosis	480% higher	475% higher	**Decrease of 5%**
Alcoholism	388% higher	579% higher	**Increase of 191%**
Accidents	185% higher	212% higher	**Increase of 27%**
Diabetes	169% higher	231% higher	**Increase of 62%**
Homicide	91% higher	41% higher	**Decrease of 50%**
Suicide	52% higher	70% higher	**Increase of 18%**
Pneumonia and flu	42% higher	61% higher	**Increase of 19%**

*Sources: U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, Office of Planning, Evaluation, and Legislation, Division of Program Statistics, (1997).

It is unclear what has propagated this appalling increase. What changes have taken place in health care, the environment, government, economy, or other factors that influence quality and length of life? One can only hypothesize. This nation was certainly in turmoil during the five years the data represents. Issues such as health care reform, toxic environments, shifting of governmental responsibilities, and an overall prosperous economy, may have made an impact; however, it is clear that these are serious increases in preventable deaths. Moreover, it is an indication that all of us must collaborate to reduce these discrepancies for Indian people.

American Indians appear to be at higher risk than other U.S. ethnic groups for mental health problems, including depression, substance abuse, domestic violence, and suicide. American Indians and Alaska Natives have the highest suicide rates of all ethnic groups in the United States, and suicide is the second leading cause of death (Borowsky, Resnick & Blum, 1999). Despite recent increases in the federal budget for mental health services for Native Americans, less than 50 percent of the estimated need for ambulatory services is being met (Nelson, McCoy, Stetter, & Vanderwagen, 1992). Many contributing issues including poverty, rural isolation, lack of transportation, and cultural and linguistic barriers compound mental stress.

The health problems experienced by Indian youth on reservations are largely caused by preventable behaviors such as tobacco use, drug abuse, immature sexual practices, poor nutrition, and lack of physical activity. Specifically, inhaled drugs tend to be a problem on reservations due to their economic accessibility. This abuse, along with other chemical abuses, creates a need for a trained medical detoxification staff who can recognize and treat hallucinations, changes in consciousness, euphoria, nystagmus, dizziness, weakness, and tremors. Competent immediate action can, in some cases, save lives and initiate a comprehensive plan for recovery.

While these behaviors may result in minimal distress during adolescence, the long term practice or lack of physical capacity that results from such unhealthy experiences during developmental years will plague individuals throughout a shortened or morbidity-ridden life. Particularly at risk are those adolescents who are both poor and members of racial or ethnic minority groups, because they are most likely to be without the necessary safety nets that help many adolescents through the second decade of life (U.S. Congress, Office of Technology Assessment, 1991).

The social dysfunction that results from the above behaviors perpetuates problems in families, personal health, schools, and communities; and also deteriorates cultural practices. Schools can play a key role in teaching youth about tribal cultures that universally support maintaining health in body, mind, and spirit.

Traditional Indian healing is an important mental health resource in Native American communities because it incorporates cultural practices that are known and trusted by patients and their families (Nelson, McCoy, Stetter, & Vanderwagen, 1992). The practice of holistic medicine in the dominant culture has received increasing public attention recently, but few non-Indian health care professionals comprehend the degree to which many American Indian cultures have developed the concept of holism (Day, 1992). Utilization of healers is usually a private matter, although in many communities traditional Indian medicine is coordinated with other health and mental health services. Physicians should be aware that their Native American patients may be using alternative forms of treatment, and they should open a respectful and culturally sensitive dialogue about this use with their patients (Marbella, Harris, Diehr & Ignance, 1998).

An issue frequently raised in regard to reservations, is health care funding. This issue concerns health care provided by the IHS. Though mandated through treaties to provide health care to Americans Indians residing on reservations, the IHS's congressional allocation has not increased over the past several years. In fact, even though the American Indian population has increased, the funding has been decreased.

To date, health care reform has not only added another obstacle for service delivery, but has had a tremendous impact on the ability of tribal governments and the IHS to determine what, where, and how to access revenue dollars from Medicare & Medicaid. Federal and State health reform laws express a clear intent to shift responsibility for health care to private sector administrative services. Native American health care programs face complex and unprecedented challenges resulting from the increased assumption of clinical operations by tribal authorities, shortfalls in Federal funding, modifications in state and Federal health and welfare programs, and intensifying involvement with managed care organizations (Noren, Kindig & Sprenger, 1998).

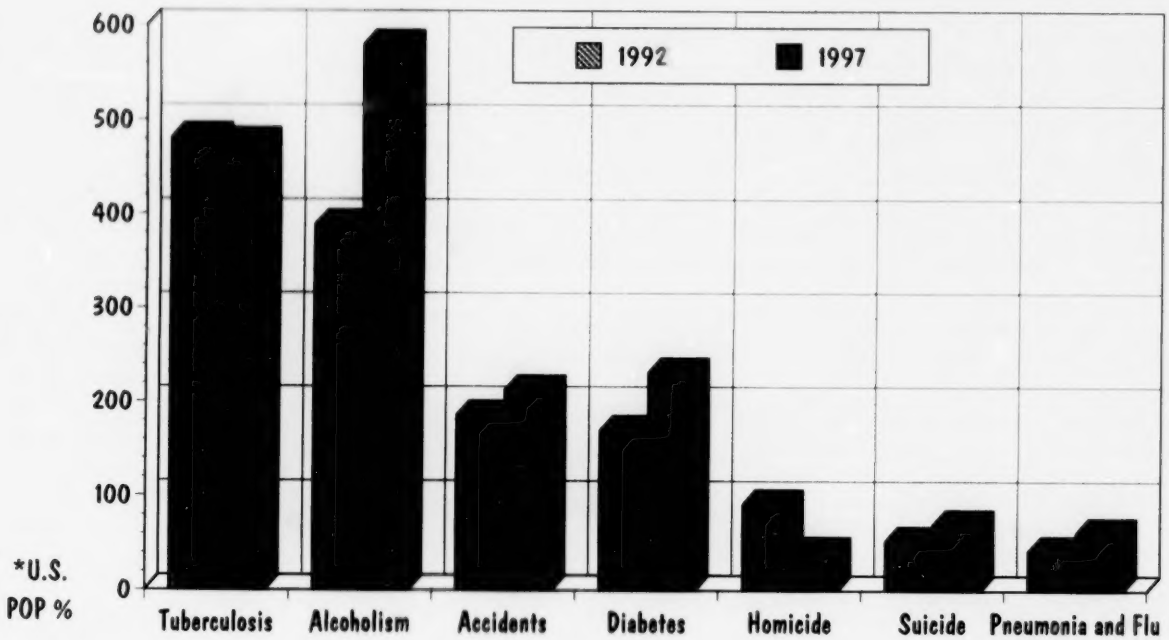
This environment has forced many tribes to advocate, through legislation, for their constituents to control health care and related services locally (e.g. self-governance). In addition, as a result of lack of federal legislation considerate of tribal governments, tribes must work to protect constituents' rights to access services within their respective states (e.g. health care financing administration waivers, and children's health insurance program funds).

In today's ever-changing environment, wherein congress is contemplating what to do with a budget surplus, there are still many challenges to be met. It is critical that access to culturally sensitive and relevant health care and health related services and programs remain available for AI/AN populations. The rural environment of most reservations leads to special challenges and increased expense for the provision of health services and programs. Generally speaking, the trend toward managing care has been devastating to rural communities. As managed care organizations profess to improve patient services through cost shifting and limiting choices for health care practitioners to those in a specific network, rural American Indians find their choices to be highly limited. Oftentimes, there is no choice.

Several vital elements of health services for American Indians require advocacy and support. A short list of such issues must include respect for traditional healing practices, recognition of diversity of cultures, consideration of traditions and beliefs, improved communication, improved long-term commitments from health service providers, alcohol and drug abuse issues, interpersonal violence, increased health promotion and disease prevention activities, development of long-term care options for elders; provision for equitable financial reimbursements, and respect of the government-to-government relationships. There is much work to be done.

As tribal governments and urban Indian organizations gain the financial resources to expand their services, perhaps the harmony and good health that Indian people once enjoyed as a natural state will be regained. There is hope that the consultation process of the reauthorization of the *Indian Health Care Improvement Act*, that demonstrated unity by tribal governments will continue to grow and cultivate dedication from Congress to honor trust obligations and promise of a healthier future for all Indian people.

American Indian and Alaska Native Health Status Indicators
Percent of Incidence Compared to the United States General Population



* Chart represents percent of incidence change, the U.S. General Population is represented as the baseline (0%). U.S. Indian Health Service, Trends in Indian Health

References

Borowsky, I. W., Resnick, M. D., Ireland, M., & Blum, R. W. (1999). Suicide attempts among American Indian and Alaska Native youth: risk and protective factors. *Archives Pediatric and Adolescent Medicine, 153*(6), 573-80.

Day, T. W. (1992). Cross-cultural medicine at home. *Minnesota Medicine, 75*(3), 15-7.

Galloway, J. M., Goldberg, B. W., & Alpert, J. S. (1999). *Primary Care of Native American Patients: Diagnosis, Therapy, and Epidemiology.* Woburn, MA: Butterworth-Heinemann.

Mahoney, M. C. & Michalek, A. M. (1999). The health status of American Indians and Alaska Natives: 2. Lessons for cancer educators. *Journal of Cancer Education, 14*(1), 23-7.

Marbella, A. M., Harris, M. C., Diehr, S., & Ignance, G. (1998). Use of Native American healers among Native American patients in an urban Native American health center. *Archives of Family Medicine, 7*(2), 182-5.

Nelson, S. H., McCoy, G. F., Stetter, M., & Vanderwagen, W. C. (1992). An overview of mental health services for American Indians and Alaska Natives in the 1990s. *Hospital and Community Psychiatry, 43*(3), 257-61.

Noren, J., Kindig, D., & Sprenger, A. (1998). Challenges to Native American health care. *Public Health Report, 113*(1), 22-33.

U.S. Department of Health and Human Services & Public Health Service. (1991). *Healthy People 2000.* DHHS No. (PHS) 91-50212.

U.S. Department of Health and Human Services, Indian Health Service, Office of Public Health, Division of Community and Environmental Health Program Statistics Program Statistics Team. (1997a). *Regional Differences in Indian Health.*

U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, Office of Planning, Evaluation, & Legislation, Division of Program Statistics. (1992-5). *Trends in Indian Health.*

U.S. Department of Health and Human Services (1997b), Indian Health Service, Office of Public Health, Division of Community and Environmental Health Program Statistics Program Statistics Team. *Trends in Indian Health.*

Wolff, E. G. C. & Marx, K. E. (1999). The Indian Health Service and Medicaid Reform: The issues surrounding 1115 waivers and the reauthorization of the Indian Health Care Improvement Act. *The IHS Primary Care Provider, 24*(3), 33-8.

Internet Web Sites

Indian Health Service
www.ihs.gov
National Congress of American Indians
www.ncai.org
National Indian Council on Aging
www.nicoa.org
National Indian Health Board
www.nihb.org
Urban Indian Health Listings
www.ihs.gov/medicalprograms/alcohol/urban98

Advocacy in Action: One Person's Experience

Fern Walter Goodhart, MSPH, CHES

Until managed care threatened the future of college health services, I never thought much about the need for advocacy. Until then, advocacy was something important that other people did, people more skilled than I. I have since learned, and believe in my bones, that all health educators must learn to advocate. Managed care is still a threat, but my workplace has become savvier in positioning itself well, and in advocating for its position.

Now I am an advocate for advocacy. To me, advocacy means working to organize, and speaking out and acting to influence policy and policy makers about issues you know and feel strongly about. It means creating change. Advocacy involves efforts to change community conditions to promote health (Altman, Balcazar, Fawcett, Seekins, & Young, 1994). Advocacy increases the power of people and groups to make institutions more responsive to human needs (Wallack, Dorfman,Jernigan, & Themba,1993). I've come to believe that advocacy requires, in Michael Pertschuk's words, a realistic hopefulness about what is possible and necessary (Wallack et al., p.viii), and that it is our professional and moral obligation to educate our communities and policy makers about our programs and experiences, with our data, literature, and partners.

Advocacy is necessary to inform public opinion and policy with community experience, literature, and research. Otherwise, only personal experience, assumptions, misperceptions, and minority opinion too often inform health policies and programs. Advocacy is a strategy that blends science and politics with social justice to make the system work better, especially for those with the least resources (Wallack et al., p.5).

I have learned that I cannot advocate by proxy. I cannot expect my association leadership to advocate in my place. In fact, my voice, with my experience, is as least as persuasive to my elected and appointed officials as professional advocates are. I have learned that the power of my vote and my pen can be strong.

My Story

I am a volunteer member of my state's HIV Prevention Community Planning Group. This statewide group serves to advise the NJ State Department of Health and Senior Services on effective interventions and priority target populations for HIV prevention. Although we have annually recommended needle exchange as a top intervention priority for HIV prevention, the commissioner and governor have never accepted our recommendation. The group felt frustrated and virtually paralyzed about the lack of political will on this issue.

Working with Professional Associations

It occurred to me that important voices for a public health issue such as needle exchange are our professional organizations, since they are politically neutral and can be seen as authentic experts in their professional area. As a member of the New Jersey Public Health Association (NJPHA), I attended a board meeting and asked for support to draft a position paper on needle exchange. The board was willing to consider the issue, and an informative discussion ensued, resulting in support for the position. I have since learned that NJPHA was interested in developing more positions on key issues as a way of getting more visibility and credibility for the association.

I drafted the position paper based on the considerable literature available, which was approved shortly thereafter. So the NJPHA, a neutral association committed to public health, now had a position advocating for needle exchange, and for decriminalization of syringe possession.

Having a position on an issue is an important start, as it educated our members, and pushed us to take a stand. That, however, was only the first step. We also joined a coalition – in this case, the New Jersey Harm Reduction Coalition – to help us focus and amplify our voice on the issue. We also realiz that we couldn't advocate alone on this issue, and joining forces with others advocating for the same cause was sound practice.

Publicizing Our Position

Understanding the need to publicize our position, the board agreed to have the position paper reworked into an editorial and sent to the major newspapers in the state. This action was timely, since legislation was pending on needle exchange (S 453) and syringe availability (without prescription in specific instances, S 267).

This was my first editorial, although I've written letters

to the editor before (in my own voice and with my own opinion). Fortunately, my employer has a public information office, which helped me rewrite the editorial to be concise, focused and timely. In fact, the news service even faxed the editorial to every newspaper in the state (actually all but one, since that one demands exclusivity – and will not print an editorial printed in any other newspaper). I also requested, and received, their fax list of media editors, so now I can directly send other editorials myself.

The NJPHA board wanted to get as much exposure for our position as possible. We saw our role of educating the public and policy makers about our position and about us. Once the editorial was printed, I sent a copy of the editorial to each of my state elected officials, and the chair of the Senate Health Committee.

Many friends and colleagues called to report that they saw my editorial. One newspaper, in fact, had juxtaposed my editorial with that of the governor's, who had an opposing view on the same issue. Soon after, a radio station contacted me for a studio interview. What wonderful publicity these gave both the issue and the Association.

Not long after the editorials were printed, the Chairman of the Senate Health Committee called, inviting me to provide testimony at their upcoming legislative hearing on the pending legislation. They contacted me because, he said, they "wanted the public health perspective." This is exactly the exposure and relationship we want with our policy makers. The bills progressed through committee, and are waiting to be posted for a full vote at this writing.

Further Steps - Training

With an experience such as this, I realized how important our public health education voice was, and yet how quiet it seemed to be. Working with the NJ SOPHE chapter, we now sponsor annual advocacy training for public health and health education professionals and students in the state. Our first training included advocacy experts from national associations, and a successful state experience with tobacco control advocacy. Our second training focused on a panel of state legislators and lobbyists, with the conversation about pending legislation, and what help they needed from us, the public health education community.

Our future training will continue this second model, as we need to strengthen our relationships with state and federal lawmakers. This is important both to promote public health education as a field in general, and public health education issues specifically. In fact, we are building a relationship wherein a state legislative aide consults with us about pending legislation. Lawmakers look to us for fact sheets containing a summary of the literature, research, and our community experience. Our advocacy committees then respond by identifying experts and creating factsheets.

Our two associations also collaborate with our advocacy committee work, sharing information and legislative alerts, and teaming up for planning conferences and developing materials. Our legislators do respond to the messages we send, although we remind our members to always include their addresses, which is legally required in order for legislators to respond. Following up with the legislators is particularly important, since they might thank us for writing, but not inform us about what position they have taken on an issue.

Legislative Scorecard

In another effort to raise the profile of public health as a field, a Rutgers University undergraduate student intern, Laurie Cancialosi, created our first state legislative scorecard for public health. With the accessibility of the internet, information about bills, votes, and committee membership was readily available. Working with a small committee from the professional associations, she identified the most salient legislation from the past year. She then indicated each legislator's vote as supportive or not supportive of public health, as determined by the committee. This scorecard can be distributed to legislators and state policy makers, the media, and be posted on the NJPHA and NJSOPHE websites. A legislative scorecard is another tool to give visibility to the field and the issues, and to hold policy makers accountable for their legislative decisions, or indecision.

Strengthening Relationships

Working with the New Jersey Harm Reduction Coalition, we cosponsored a statewide harm reduction conference, increasing our profile and creating new partnerships. Policy makers and legislators, and newspaper editors were included as panelists in the program. NJPHA annual awards are given to a selected media person every year. This past year, a special president's award was given to the two senators who sponsored the needle exchange legislation, to show our support, strengthen our relationship, and increase our visibility with them.

I have become emboldened by these experiences. I have since written, and had printed, an editorial on sole domestic partner benefits in the workplace, another NJPHA position. I regularly correspond with my state and federal legislators, either by letter or email, whichever they prefer. I connect my perspective to my professional experiences, include resources, and offer additional information. I also try to write thank you notes after supportive votes. In addition, I'll often modify my letter to a legislator and send it to the editor of my local newspaper as a mechanism to inform readers of a public health education view.

Whenever I'm in Trenton or Washington, D.C., I make a point of meeting with my legislators or their aides. I still find these meetings intimidating, as my heartbeat races and my palms get clammy. Nevertheless, these opportunities to revisit pending health education issues, leave factual infor-

mation, and remind them that I care and am paying attention with my vote, and potentially with votes of my association's members, are too important to pass up. Often these meetings are short, which lowers my anxiety. In addition, I follow-up with a letter summarizing my position.

As an anonymous Public Health worker once said, "Public health workers will become tourists in public health if they don't get political." I'm learning the truth in that statement, for I see all too often how public health policy is being crafted without the hand of public health. So now I'm watching more carefully, speaking out, writing, calling and collaborating. You can, too.

References

Altman, D.B, Balcazar, F.E., Fawcett, S.B., Seekins, T., & Young, J.Q. (1994). *Public health advocacy: Creating community change to improve health.* PaloAlto, CA: Stanford Center for Research in Disease Prevention.

Wallack, L., Dorfman, L., Jernigan, D., & Themba, M. (1993). Media advocacy and public health: Power for prevention: Sage Publications.

Advocacy Groups for Hispanic/Latino Health Issues

Helda Pinzon-Perez, PhD & Miguel A. Perez, PhD

Introduction

Health educators have a responsibility to address not only the preventive needs of their target populations, but also the just distribution of economic and social justice opportunities. Unfortunately, this area has received insufficient attention in professional preparation programs and has not been assigned high priority by practitioners. In those cases where it has been practiced, it has not been coordinated, has been in response to specific emerging issues, or it has lacked theoretical bases (Howze and Redman, 1992).

The Role Delineation Project provided the foundation for the development of a framework designed to establish entry level competencies for health educators (National Center for Health Education, 1980). Among those competencies we find the implicit requirement for health educators to be proactive in advocacy issues for the populations they serve. Responsibility VII requires health educators to work with individuals, groups, and organizations to promote the communication of health and health education needs, concerns, and resources. More specifically, health educators are expected, as stated in Competency B, to predict the impact of societal values systems on health education programs (National Task Force on the Preparation and Practice of Health Educators 1985). Clearly, Responsibility VII requires health educators to extend their scope to work and be proactive advocates for the environmental and political needs of the populations they serve.

What exactly does advocacy entail for health educators? Health advocacy can be defined as the actions or endeavors individuals or groups engage in order to alter public opinion in favor or in opposition to a certain policy. Health advocacy also entails the philosophy espoused by Paolo Freire (1973) which indicates that it is essential to empower our populations to achieve their goals, in our case, their optimal health status. Therefore, health advocacy requires health educators to be well informed about the needs of their population and to be aware of national, state and local policies which might affect their populations. Furthermore, they need to share their political abilities in order to empower the populations to continue advocating for themselves even after the health educator has left the community.

This can be accomplished through the development. Advocacy groups study public policy issues and analyze how they affect the social and economic future of communities. Advocacy networks attempt to empower people to become responsible consumers of health services and to take an active role in public policy issues through strategies such as policy analysis and development, coalition building , education training, and media outreach.

The need to be strong advocates has been underlined by Stockdill (1992) who, drawing upon lessons learned in mental health advocacy, has suggested that unless strong advocacy roles are presented, our ability to foment growth and direction of education and research programs might be imperiled.

US Hispanics

Individuals of Hispanic/Latino descent are the second largest minority in the U.S. It is estimated that there will be approximately 98 million Hispanics/Latinos in the U.S. by the year 2050 (U.S. Bureau of the Census, 1999). Given the rapid growth of this population in the U.S., it is not surprising that efforts are underway to provide comprehensive and culturally-sensitive programs to this population group (Pinzon & Perez, 1997). These efforts have been in part the result of the active involvement of advocacy groups and organizations concerned with the health of the Hispanic/Latino population.

Advocacy among and for Hispanics

Advocacy issues among Hispanics in the US has been undertaken by grass-root and national organizations which have traditionally dealt with specific areas of endeavor. Current research, however, suggests that effective health advocacy issues among Hispanics need to extend beyond symptoms and include communication, networks, and legal issues (Baker et al., 1997).

Advocacy issues for a growing population with many needs can be overwhelming for one person to undertake. It is, therefore, imperative for health educators to collaborate with one another and to learn about local, state, and national organizations already advocating for US Hispanics. This article presents information regarding some of the advocacy groups concerned with Hispanic/Latino health issues within a multicultural perspective.

The National Latina Health Organization (NLHO) is primarily concerned with raising awareness about Latina women's health , bilingual access to quality health care, and

the development of empowerment skills among Latinas. These goals are obtained through outreach efforts, research, and educational activities such as conferences, forums, training of self-help facilitators, and the edition of a newsletter that presents legislation affecting Latinas (Latino Coalition for Healthy California [LCHC], 1999)

The National Council of La Raza (NCLR) keeps track of the economic trends affecting Hispanic Americans and provides a public forum to analyze the policies at the micro and macro level affecting Hispanic Americans. Poverty issues are of special interest for NCLR. Some of the priority areas addressed by this organization include education, employment, media advocacy, and multiple analyses of the validity of policy options. (NCLR, 1999).

The Latino Issues Forum (LIF) is an entity that acts as a public policy and advocacy institute for Hispanic Latino groups. LIF is a non-profit public organization dedicated to advancing new and innovative public policy solutions on issues such as access to higher education, economic development, health care, citizenship, regional development, telecommunications, and regulatory factors. The LIF also serves as a clearinghouse to provide the news media with accurate information about the Latino community for a fair and effective coverage of issues pertaining to this population. (LIF, 1999).

The Latino Coalition for a Healthy California (LCHC) is another advocacy group and a leading voice for Latino Health in California. The LCHC is a proactive organization in developing, proposing and supporting policies that promote wellness, health promotion and healthy behaviors for the Hispanic Latino culture. LCHC specializes in advocating for linguistically and culturally-competent services that reinforce the dignity of human-beings regardless of their immigration status and income. The main advocacy priority areas for this organization are HIV/AIDS, diabetes, cancer, cardiovascular disease, Mental health, tobacco use cessation, and prenatal care. LCHC advocates for the emphasis of cultural and language issues and provides literature in English and Spanish through multiple networks such as the Rapid Response Network (LCHC, 1999).

The Rapid Response Network (RRN) has also served as an advocacy medium for Hispanic Latino populations to organize community efforts related to policy issues affecting this particular population at the local, state, and federal levels. Advocacy strategies used by this network include letters and phone calls to state and local representatives, as well as postcards campaigns. Some examples of issues to which the RRN has responded include reactions to laws attempting to deny prenatal care to undocumented women, proposed cuts to Medicaid services, and environmental issues (LCHC, 1999).

The Latino Health Institute (LHI), created in 1987 by a group comprised of Hispanic Latino community activists and health professionals, has been a leading organization in the State of Massachusetts in promoting the health care rights and needs of this particular population. Although their major focus has been on Latino health care, their philosophy emphasizes the understanding of health practice, theory, and research as influenced by multicultural forces and, as such, this organization often undertakes programs that involve multicultural populations. The current program agenda of the LHI focuses on studies related to the treatment and decision-making by HIV positive people, alternative and complementary healing practices among Hispanic/Latino women, prostate cancer awareness and screening, breast cancer screening, poly-pharmacy management by Hispanic/Latino elders, and tobacco use prevention and cessation (LCHC, 1999).

The California Multicultural Health Information Network (CMHIN) is one example of the many advocacy pluri-cultural network groups in the U.S. This network provides a comprehensive data base of health personnel and programs designed to serve ethnic minority populations. Some of the organizations that are involved in this network include the California Department of Health Services-Office of Multicultural Health, the Latino Coalition for a Healthy California, The Asian & Pacific Islander American Health Forum, the California Black Health Network, and the California Rural Indian Health Board (CMHIN, 1999).

The National Coalition of Hispanic Health and Human Services Organizations (COSSHMO) is another organization that promotes advocacy for Hispanic/Latino populations. The purpose of this advocacy organization is to improve the health and well-being of Hispanics/Latinos in the United States. COSSHMO is known for its partnerships with government entities in developing and delivering quality health care services to Hispanics/Latinos. Among it most recent collaborative ventures is its vaccination campaign in collaboration with the Centers for Disease Control and Prevention. Other services offered include the National Hispanic Prenatal Hotline and the Project ALEA (Aire Limpio para su Familia/Clean Air for Your Family) (COSSMHO, 1999).

The Children's Defense Fund's (CDF) purpose is to provide a strong and effective voice for American children of all ethnic groups. CDF's goal is to educate the nation about the needs of children and encourage preventive investments in children before they get sick, drop out of school, suffer family breakdown or get into trouble (CDF, 1999).

The Institute for Puerto Rican Policy, Inc. is a non-profit policy analysis organization concerned with issues affecting the Puerto Rican community in the United States. The IPR regularly reports and sponsors forums on a variety of public policy issues (IPRNET, 1999).

The National Association of County and City Health Officials (NACCHO) is a membership organization for local health departments throughout the U.S. NACCHO is dedicated to improving the health of people and communities by assuring an effective local public health system (NACCHO, 1999).

The preceding list of entities advocating for health and other socio-economical issues among US Hispanics is not meant to be comprehensive. It is provided instead as a start

ing point for those individuals seeking to become active advocates for Hispanics in those areas.

Conclusion

Active public involvement through advocacy groups has been shown to be an important strategy to insure equity in the accessibility of health services for multicultural groups. The role of health educators as advocates is without any doubt an important element for consideration and further discussion. Hispanic/Latino health educators and other professionals from various cultural and ethnic backgrounds ought to analyze their role as advocates and agents for change. Health educators advocacy efforts for Hispanics in the US will undoubtedly result in a more comprehensive service delivery paradigm, continuity of care and decreased social isolation experienced by some Hispanics/Latinos.

References

Baker, E., Bouldin, N., Durham, M., Lowell, M., Gonzalez, M., Jodaitis, N., Cruz, L., Torres, I., Torres, M., and Adams, S. (1997). The Latino health advocacy program: A collaborative lay health advisor approach. Health Education and Behavior, 24(4), 495-509.

California Multicultural Health Information Network (1999). General Description. Available on-line at: http://www.apiahf.org.

Children's Defense Fund. America's Strongest Voice for Children. Available on-line at: http://www.childrensdefense.org.

COSSMHO (1999). COSSMHO Calls on EPA to Back Up Hispanic Strategy with Budget. *The COSSMHO Reporter*, p. 6.

Freire, P. (1973). *Pedagogy of the Oppressed.* New York: Continuum.

Howze, E., & Redman, L. (1992). The use of theory in health advocacy: Policies and programs. Health Education Quarterly, 19(3), 369-383.

Latino Coalition for a Healthy California-LCHC (1999). Advocacy Vehicles. Available on-line at http://www.lchc.org.

Institute for Puerto Rican Policy Inc. (1999). IPRNET. Available on-line http://www.iprnet.org.

Latino Issues Forum (1999). Boletin/Bulletin. Celebrating 10 years of Service to the Latino Community. Available on-line http://www.lif.org.

National Association of City and County Health Officials. (1999). National Association of City and Council Health Officials. Available on-line at http://www.naccho.org.

National Center for Health Education. (1980). Initial role delineation for health education. HRA Publication No. 80-44, April. Washington, DC: US Department of Health and Human Services.

National Coalition of Hispanic Health and Human Services Organizations. Mission Statement. Available on-line at http://www.cossmho.org

National Council of La Raza-NCLR (1999). NCLR Policy and Programs. Available on-line http://www.nclr.org.

National Task Force on the Preparation and Practice of Health Educators. (1985). A framework for the development of competency-based curricula for entry-level health educators. New York: Author.

Pinzon, H.L., & Perez, M.A. (1997). Multicultural Issues in Health Education Programs for Hispanic-Latino Populations in the United States. *Journal of Health Education*, 28(5), 314-316.

Stockdill, J.W. (1992). A government manager's view of mental health advocacy groups. Administration and Policy in Mental Health, 20(1), 45-55.

U.S. Bureau of the Census (1999). Resident population of the United States: Middle Series Projections, 2035 - 2050, by Sex, Race, and Hispanic Origin, with Median Age. Available on-line at: http://www.census.gov/population/projections/nation/nsrh/nprh3550.txt

How to Effectively Use the Internet for Advocacy

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We live in a world of unrivaled technological innovation (Saha, 1998). Today, those with access to technology are encouraged to utilize it in myriad ways from shopping "online" to making travel arrangements, to researching virtually any topic via the Internet. Many political and interest groups have recognized the usefulness of technological innovation and proliferation in communicating with members and interested individuals. Noteworthy are the groups who may not support some health education initiatives, and who have made exceptional use of the Internet and other technology to facilitate development of grassroots support. Health education, as a profession, has not fully realized the potential of the Internet as a tool in advocacy. This article discusses the Internet, examines use of electronic mail and information and resource retrieval for advocacy purposes, and sets forth a plan for use of the Internet as an instrument for the enhancement and support of health education professional advocacy.

The Internet

In the simplest of terms, the Internet is a tool for communication from one computer to another (Saha, 1998). When thought of as a tool, the usefulness of this network of networks becomes apparent. It allows quick, economical communication of information to individuals and large groups of people connected to the Internet. It also makes available a staggering amount of information on virtually every imaginable subject. One example of the usefulness of the Internet is the plethora of political and interest groups using the Internet to communicate and provide information. Political and interest groups can provide information and communicate in ways and with ease unimaginable ten years ago.

The Internet is a network of individual computers connected to an array of computer networks (Gibson, 1999). A computer network is a group of computers that are linked together in some fashion. The network allows computers to share information and interact in a variety of ways. Some networks connect a central computer and remote stations (referred to as a local area network or LAN). Others, including the Internet, permit any computer to interact with any other that has access to the network. The Internet, or network of networks, allows people throughout the world to economically communicate and access a wide array of information. For the most part, access to information is unrestricted. If one can connect to the Internet, access to most sources of information is free. Thus, information is readily available to anyone with a connection to this vast network of networks.

The Internet began as a project started by the U. S. Department of Defense (DOD) in 1969 (Gibson, 1999; Rundle, 1998). The necessity of reliable computer networking between DOD and military researchers spurred development of the Advanced Research Projects Administration Network (ARPANET). This network began as a small connection of three computers in California and one in Utah. The success and growth of this network quickly spanned the continent. The growth was so rapid that two distinct networks (one military and one nonmilitary) soon developed (Rundle, 1998). They remained connected through a technical innovation called Internet Protocol (IP). The IP allows any computer with access to the network communicate with other networked computers. The development of Internet Protocol has revolutionized our worldview. The ARPANET was shut down for technical and political reasons (Rundle, 1998). The National Science Foundation (NSFNET) entered the fray with a plan to network supercomputers for research and educational purposes (Rogers, 1998). The NSFNET workload was taken over by commercial networks (Gibson, 1999). Today, wide ranges of commercial and public networks are connected to form what we know as the Internet.

It is beyond the scope of this article to explain all the applications available through the Internet. The most common uses of the Internet, electronic mail and information and resource retrieval, are the applications considered in this article.

Electronic Mail

Electronic mail (e-mail) is the most widely used service of the Internet (Marson, 1997). Many professionals, especially in academe, have become almost dependent on this communication tool. For example, a professor or student subscribes to eleven professional, content, and political or interest group mailing lists. These mailing lists, as well as personal e-mails, generate approximately 150 or more messages each day. Perusal of the messages occupies about 30 minutes each morning. It is, however, time well spent. The professor or student is connected to the pulse of the profession. He or

she receives messages regarding important legislation at the state and national level. Furthermore, he or she remains aware of the actions and propaganda of opposition groups.

Mailing lists allow a subscriber to connect to many people with similar interests. The mailing list itself has an address and anything sent to the list is sent to all subscribers. The subscribers can delete, read, or reply (via the list or personally) to messages. The result is a stream of communication related to whatever topics strike the interest of subscribers. Mailing lists, and electronic mail in general, should be viewed as a tool. These tools can help inform your professional growth and practice. Subscription to a mailing list operated by a group generally opposed to health education issues can be an educative experience. At the very least, such a subscription will allow you to be aware of and ready for the positions and arguments of your opponents. An abundance of political and interest mailing lists are available on topics ranging from arts to society. Liszt.com (http://www.liszt.com/) provides a reliable listing of mailing lists by content or interest area.

Electronic updates or notifications are another example of using e-mail for advocacy purposes. These are not mailing lists as described above. Rather, they are one-way communication tools, allowing a political or interest organization to communicate with supporters in an inexpensive, yet timely manner. Several political and interest groups provide regular informative electronic mailings about topics ranging from pending legislation to cultural and philosophical writings. The Family Research Council (FRC) provides an excellent example of effective use of electronic mail to develop and inform advocacy efforts. The FRC exists to reaffirm and promote nationally, and particularly in Washington, DC, the traditional family unit and the Judeo-Christian value system upon which this country is built. The FRC uses e-mail to notify supporters and subscribers of pending legislation regarding a variety of topics. This process also connects supporters and subscribers to the FRC website. Subscriptions can be acquired for no charge at the Family Research Council website (http://www.frc.org). The FRC supplies, via electronic mail, weekly updates on legislation and social issues. For example, electronic mailings have contained information and updates regarding hate crime legislation, school prayer, sexuality education, homosexuality, tax credits or cuts, foreign policy, and family values.

The People for the American Way (PFAW), an organization intended to promote full citizen participation in our democracy and safeguard the principles of our Constitution from those who threaten the American dream, utilize electronic mail to inform a network of advocates. The "Activist Network" utilizes electronic mail to transmit alerts on issues important to subscribers. PFAW tells subscribers how to contact your Senator or Representative when voices need to be heard, and provides information and resources to help make a difference. Subscription information is found at the People for the American Way website (http://www.pfaw.org/activist/).

The health education profession has many mailing lists to which in-service or pre-service professionals can subscribe. The most noteworthy health education professional mailing list is operated by Dr. Mark Kittleson at Southern Illinois University, Carbondale. Dr. Kittleson's list has grown over the years from a fledging, futuristic concept to the virtual professional office lounge or meeting place. The HEDIR (pronounced "Heeder") provides a professional forum for topics of concern and interest to the profession. Messages are archived (http://www.hedir.siu.edu/) and can be viewed by anyone with access to the Internet.

While a useful professional tool, the potential of the HEDIR as an advocacy mechanism has been unrealized. The HEDIR, and the profession in general, has not developed a systematic, consistent mechanism for advocacy.

Eta Sigma Gamma (ESG) operates a mailing list. This list is intended to facilitate communication among members. It is certainly feasible that such a list could become a useful advocacy tool. Individuals or chapters could use the ESG mailing list to inform other students about important political and interest issues regarding any topic of concern. For more information on the ESG mailing list visit the Eta Sigma Gamma website (http://www.cast.ilstu.edu/temple/esglistserv.htm).

Information and Resource Retrieval

Computers throughout the world store information and files that are free for the taking. The information and files contain all types of information including government documents, historical or biographical information, epidemiological and demographic data, entire texts, sports and travel information, free and shareware software, and almost anything you desire. Tools such as web-browsers allow an individual to search the Internet for computers that contain specific information sought.

An example will help illustrate the usefulness of this tool. A health educator at a local health department in Illinois seeks information to help make a case for a coordinated school health program (CSHP) in her local area. She uses a search engine and searches the Internet for information on CSHPs. She uses the Micro Soft Network WebSearch and finds 22,415 sites related to this topic. The health educator can review the sites from her office or home and download information that might help support her presentation. She can seek funding information and find 10,136 sites related to funding of coordinated school health programs. Rather than a lack of information and resources, today health education professionals must deal with a profusion of facts and sources.

With such a wide range of information and resources available the trustworthiness and authenticity of information should be questioned. In practical terms anyone with access to the network and basic computer skills can post information and resources on the Internet. This creates new and

unique problems. This wealth of information and resources necessitates an informed consumer. Without basic knowledge of the topic and source of information or resources, the consumer can be duped by slick presentation of "fact." The ability to assess the accuracy and authenticity of web-based information and resources is quickly becoming an essential skill.

Websites intended for advocacy information and resource retrieval typically include some mechanism for communication of pertinent issues and access to information and resources. Each of the fifty or so advocacy websites visited in preparation for this section contained some mechanism to facilitate communication between interested individuals and the political or interest group. Almost all of websites provided information and resources. The Eagle Forum website provides a detailed questionnaire for school board candidates (Eagle Forum, 1999). This questionnaire is intended to help inform efforts by Eagle Forum members and other interested individuals to ascertain the position of school board candidates on a wide range of issues including many related to coordinated school health programs. Advocacy sites typically link to other websites of similar interest. Finally, many of these sites provided action alerts regarding a range of topics regarding immediate attention. Advocacy alerts notified the viewer of impending legislative action and encouraged specific courses of action as well as contact information regarding legislators at the national and state levels.

From an advocacy standpoint, the most useful mechanisms provided via the Internet are sites intended to inform the citizenry regarding the process of governance. For example, "Thomas: Legislative information on the Internet" (http://thomas.loc.gov/home/thomas.html) provides Congressional news, House of Representatives and Senate directories, Congressional Internet services, information regarding the legislative process, Bill texts and summaries, Congressional records, committee information, and much more. This "one-stop" source of information can help inform advocacy efforts.

The following practical example will demonstrate the usefulness of the Internet as an advocacy tool. Ted is a School Health Coordinator with a school in Texas. He is interested in determining if any legislation regarding school health programs is before Congress. Ted visits "Thomas" and selects "Bill Summary and Status of the 106th Congress. He decides to search for the subject "school health programs" and finds 14 items indexed as pending legislation regarding school health programs. Ted is interested in House Resolution (H.R.) 300, a bill to authorize the Secretary of Health and Human Services to fund adolescent health demonstration projects. "Thomas" provides useful information to help Ted learn more about H.R. 300. He can review a summary of the bill including a detailed legislative status report and amendments. Ted can find the page number of the bill within the Congressional Record. He can also determine if the bill has been referred to a subcommittee or another committee. In the case of H.R. 300, Ted learns the bill has been referred to the Health and Environment Subcommittee of House Commerce committee. Ted uses "Thomas" to check the subcommittee membership and discovers that his representative sits on that subcommittee as well as three other Texans. "Thomas" allows Ted to link to the House of Representative website where he can access the homepages of each Texas representative on the Health and Environment subcommittee. Each congressional member's homepage includes contact information making it easy for Ted to inform the legislators regarding his position on H.R. 300.

A Plan for Using the Internet for Health Education Advocacy

The profession of health education has underutilized the Internet as an advocacy tool. As the profession becomes aware of the essentiality of professional advocacy, the need for a systematic approach to Internet-based advocacy becomes necessary.

Professional Organizations

Several professional organizations have developed Internet-based advocacy tools. For example, the American Public Health Association has included advocacy information at its website (http://www.apha.org/legislative/index.html) and implemented a mailing list that includes advocacy alerts. Professional organizations, under leadership of the Coalition of National Health Education Organizations (CNHEO) (http://www.med.usf.edu/~kmbrown/CNHEO.htm), should begin to discuss Internet-based advocacy. A workable plan might involve a contribution by each professional organization to one advocacy website. The placement of political and interest information and resources at an easy-to-access, "central" location (i.e., the CNHEO website) should help coordinate advocacy across the profession. The advantages of a "central" site include access by professionals across the spectrum of health education worksites. Development of a "central" site would ensure that health educators from each work setting could remain current regarding advocacy issues throughout the profession. Another plan would include each professional organization placing advocacy information on their respective websites. Limitations of such a plan include duplication of effort. Professional organizations may also be unlikely to access information and resources from organizations to which they do not belong. Problems may also arise if Internet-based advocacy tools are not updated in a timely manner.

Professional organizations could make a commitment to develop more efficient use of electronic mail to inform advocacy efforts. Each professional organization should seek the capacity through national offices or membership to regularly provide electronic mailing alerts regarding appropriate

advocacy concerns. One way for professional organizations to communicate advocacy issues would be to develop a two-level approach of mailing lists for members and posting of alerts on the HEDIR.

Eta Sigma Gamma (ESG) plays a special role among professional organizations. As the sole organization focused on student development through teaching, research, and service, ESG should make a commitment to informing pre-service professionals regarding advocacy. The honorary could place advocacy information at its website (http://www.cast.ilstu.edu/temple/esg.htm). ESG could also encourage use of its mailing list as a tool for notifying students regarding key professional issues.

Professional Preparation Programs and Pre-service Professionals

Programs of professional preparation should train pre-service professionals in all aspects of advocacy. Training might include use of the Internet as an effective tool in efforts to influence public policy. Advocacy skills and information can be delivered to students through an array of learning strategies. Students could be required to access valid information and resources regarding a public policy topic and develop a plan for using Internet tools to generate action and support. Course assignments might involve creation of a mailing list or development of an advocacy web page. Projects based on skill development will help develop a practice of advocacy that will accompany pre-service professionals throughout their professional practices.

In-service Professionals

An appreciation of Internet advocacy tools is becoming an important aspect in health education professional practice. Awareness requires a willingness to dedicate time and effort searching for and learning about Internet tools designed to inform regarding political and policy issues. The Internet provides a wealth of information and resources that can help inform professional practice and advocacy efforts. It be hooves all professional health educators to avail themselves of any mechanism that can help facilitate advocacy efforts. One hour per week spent assessing "Thomas" or opposition websites can help the health educator maintain a level of vigilance regarding current public policy issues.

Individual professionals can work to provide resources for colleagues. Temple, Lyde, and Wiley (1999) have created a website to help inform fellow professionals about efforts of opposition groups. Other professionals should devote time and effort to development of similar websites related to local, state, and national public policy issues.

The Internet cannot advocate or influence public policy. It is merely a single tool in the toolbox of advocacy strategies available to the profession. Efficacious use of this tool requires a coordinated, systematic approach. The profession of health education has yet to actualize a profession-wide plan for the utilization of the Internet as a device to inform and support professional advocacy. It is time health education recognizes the usefulness of the Internet. A valuable lesson can be learned from organizations that have employed the Internet as an instrument to advise and assist their specific agenda or efforts. Such groups have not waited for another group or organization to produce websites or mailing lists. They have created state-of-the-art mechanisms aimed at informing and motivating supporters. Their membership has dedicated the time and effort necessary to access the aforementioned information tools. Supporters have proactively involved themselves in public policy development in part based on the efficiency and application of the Internet. Health education can hardly afford to accept a reactionary stance related to Internet advocacy.

The time is now. Health education advocacy efforts should merge onto the "information superhighway" known as the Internet. All professional organizations, as well as in-service and pre-service professionals, should examine the contributions they can make to development of an Internet-based advocacy network. A connection, readily accessible by all professionals, that can enhance and support advocacy efforts through communication and provision of information and resources is a necessity. This powerful tool should not be overlooked or underestimated. The Internet can serve as a key tool in the profession's effort to create systemic change that will help produce a healthier world.

References

Eagle Forum. (1999). School board candidate questionnaire. [Online] Eagle Forum. Available: http://www.eagleforum.org/questionnaire/school_board_q.html [1999, September 22].

Gibson, S. (1999). The history teacher's guide to the Internet. *Teaching History, 95* (2), 42-45.

Marson, S. M. (1997). A selective history of Internet technology and social work. *Computers in Human Services, 14* (2), 35-37.

Rogers, J. D. (1998). Internetworking and the politics of science: NSFNET in Internet history. *The Information Society, 14* (3), 213-216.

Rundle, D. A. (1998). Today's history – Internet history. *History Today, 48* (1), 14 – 18.

Saha, A. (1998). Technological innovation and western values. *Technology in Society, 20* (4), 499-503.

Temple, M.A., Lyde, A. R., & Wiley, D. (1999, July 12). Health Education Advocacy. [Online]. Available: http://www.cast.ilstu.edu/temple/hedad.htm

Putting Advocacy in Action

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More children recognize Joe Camel than Mickey Mouse (Advocacy Summit, 1999a). Health educators realize, as a result of research like 'Joe Camel,' that a great deal of time, effort, and money goes into influencing people's behaviors. Some of that effort specifically encourages people to initiate or continue very negative health behaviors. Corporate America knows that success often relates directly to the efficacy of marketing (even when the product contributes to negative health). Social marketers agree that social programs, such as health promotion programs, would also benefit dramatically from effective marketing. Health educators frequently spend much of their time, as they should, assessing the needs of communities and planning, implementing, and evaluating programs, leaving little time and money for full force marketing efforts. National health education leaders agree, however, that health educators must become more effective marketers. Cohesive actions on behalf of the discipline by health education professional organizations may well create a similar effect to that of a major marketing campaign by a large company.

Advocacy may be a means by which the health education discipline can produce cohesive action. Advocacy is actively working to change the social, political, legal, economical, and medical environments; it is making a change in society. It is standing up for individuals who cannot. Advocacy is a tool which, when used correctly and effectively, can have a tremendous impact on the health of the public. Leaders in the discipline of health education increasingly recognize that the discipline's mission is to address not just individual health, but the social, political, and economical structures that serve as barriers to community health and wellbeing. Health educators serve as leaders in addressing conditions that diminish health; however, many health educators complete professional preparation programs that do not provide any information or training in advocacy.

The process of advocacy is many things to many people. It might be lobbying on Capital Hill in Washington, DC, with the purpose of educating and influencing policy makers; encouraging insurance companies to cover prevention services; or standing up at a school board meeting to campaign for a comprehensive health education curriculum. Advocacy can be accomplished locally or nationally, directed toward policy makers of all kinds, and can be used to change many environments.

Historical Perspective of the Advocacy Summit

In a sense, research like 'Joe Camel' and knowledge that the health education organizations must present a cohesive front represented the impetus for the development of the 21st Century Partnership. Although the discipline of health education is not new and leaders in the field have encouraged health education professional organizations to collaborate for many years (Nolte, 1996), there continues to be a need for concerted efforts on the part of health educators. A conference entitled 'The Health Education Profession in the Twenty-First Century: Setting the Stage,' initiated the "Partnership" that included representation from ten health education professional organizations. Twenty-four health education leaders met at the conference that convened in Atlanta, Georgia on June 16-17, 1995. "The forum was an attempt to initiate ideas that would stimulate actions to further the profession" (Nolte, 1996, p. 3). Participants began the development of goals to direct the profession and identified some of the actions that would be necessary to accomplish the goals. The following six focal points, listed in the Conference Proceedings, categorize the goals decided upon by the participants: promoting the profession, research, advocacy, professional preparation, quality assurance, and dynamic/contemporary practice. Each organization determined the degree to which they could focus on each goal. Advocacy for health was an action that virtually all organizations felt warranted attention and most agreed to make it a priority (Nolte, 1996).

The Society for Public Health Education (SOPHE) agreed to spearhead a major advocacy activity called the Health Education Advocacy Summit. The purpose of the Summit was to provide an opportunity for health educators to learn about advocacy, receive skills training for working with legislators, visit legislators, and plan for ongoing advocacy action. That very successful first summit convened in Washington, DC on March 28-30, 1998. Nine health education professional organizations sent three to five representatives to the summit. The second summit, spearheaded by SOPHE, convened on April 10-12, 1999. The objectives for both summits stated that at the end of the event participants would be able to:

1. Explain the legislative process to other members of their organization.

2. Articulate a position on behalf of health education related to legislation on selected health issues.
3. Identify two to three strategies for on-going advocacy work as part of their national organization's advocacy agenda.
4. Visit legislators to advocate for the selected health issues.

Participants at both summits considered them to be extremely beneficial. In general, they felt in was an invaluable opportunity not only to gain advocacy skills but also to educate the members of Congress about the discipline of health education. Participants strongly supported the idea of a third summit to be held in the spring of 2000.

The success of both summits resulted, in part, from a combination of training and action. A planning committee selected important health issues with input from their organizations. Advocacy experts taught about effective lobbying skills and provided information about the legislative process and the selected health issues. After the training, participants visited key members of congress to encourage specific actions in regard to the selected issues. Participants discovered that visiting members of congress or their staff is both fun and worthwhile with adequate preparation. They also learned that advocacy requires more than attending an advocacy summit once a year. An effective advocacy effort is ongoing, requiring building relationships with legislators
and staff, updating information for them, and consistent visits.

Summit Activities

Both summits began with training sessions for creating and delivering effective messages. Experts such as Scott Balin (American School Health Association [ASHA] lobbyist and staff Member for the Campaign for Tobacco Free Kids), Barbara Levine (owner of Levine and Associates, a public health advocacy consulting firm), Jen Wierwille (formerly the Director of Grassroots Advocacy at the American Public Health Association [APHA]), Michael Splain (Director of Congressional Relations at the Alzheimer's Association), and Donna Crane (Director of Congressional Affairs at APHA) taught the skills building and informational sessions. A compilation of the creating an effective message skill can be found in Figure 1. A list of important terms that were discussed at the summit can be found in Figure 2.

Participants at the summits learned the importance of knowing the subject before meeting with a legislator. The topics that were selected for the advocacy summits were considered important and pressing issues that required immediate advocacy action. The Centers for Disease Control and Prevention (CDC) support many prevention programs like the Breast and Cervical Cancer Mortality Prevention Program, the Tobacco Control Programs, the Diabetes Program, and the Cardiovascular Disease Prevention Program. When compared to the National Institutes of Health (NIH) which supports minimal prevention efforts, the CDC receives much lower appropriations from the federal government. Appropriations to NIH and

Figure 1 Tips for Creating and Delivering Effective Messages to Legislators

Use Advocacy Tools
- Knowledge
- Coalitions and Partnerships
- Lobby
- Grassroots Activities
- Media
- Technology

Understand the Legislative Process

Prepare and Communicate the Message Carefully
- Keep the Message focused
- Make the Information Relevant to the Audience
- Provide Correct Information
- Consolidate and Simplify the Information
- Tell About Coalitions and Grassroots Activities
- Give cost-effectiveness Information
- Involve many people in the Message
- Get a Commitment when Possible
- Rehearse the Message

Follow-up
- Write Thank You Notes
- Mention the Commitment Made
- Call Again

Figure 2 Advocacy Terms

Advocacy. Actively working to change the social, political, legal, economical, and medical environments; it is making a change in society
Lobbying. *To conduct activities aimed at influencing public officials and especially members of a legislative body on legislation.
Appropriations. Money that has been set aside for a specific purpose.
Entitlements. *A government program providing benefits to members of a specific group or the funds supporting or distributed by such a program.
Discretionary. *The power of free decision or latitude of choice within certain legal bounds; purchasing power.
Constituents. *One of a group who elects another to represent him/her in public office.

Note. Definitions with * were excerpted from *Webster's Ninth New Collegiate Dictionary*

CDC are made each spring. Therefore, the CDC appropriations were targeted advocacy appropriations, legislation regarding the "Patients Bill of Rights' and Tobacco Prevention were targeted in 1998 and 1999. In 1999, the Education Reauthorization Act and Tobacco Legislation were also targeted. The next section contains a brief discussion of each of the selected issues for 1999.

Selected Health Issues

Cardiovascular Disease Prevention Program

Cardiovascular disease (CVD) is our nation's number one cause of death, accounting for 42% of all deaths. About one fourth of the American population lives with some form of cardiovascular disease, and each year hundreds of thousands are disabled as a result of this disease. In 1999, the estimated cost related to cardiovascular disease in the US was $274 billion (CDC, 1999a).

Comprehensive health education programs have been proven to be effective in reducing the number of individuals who experience some form of heart disease. Prevention efforts help those who have a higher risk for cardiovascular disease to learn ways to reduce and prolong the onset of cardiovascular disease. The CDC was funded at $10.9 million dollars for fiscal year 1999. Currently, only eight states are funded through this money. The advocacy efforts of the summit participants were in support of an increase of funds to ensure $20.9 million for fiscal year 2000. This increase will allow more states to participate in Comprehensive Health Education and CVD surveillance programs (Advocacy Summit, 1999b).

Tobacco Control Programs

Until 1996, tobacco products were, for the most part, unregulated in the United States. This changed when the Food and Drug Administration (FDA) labeled tobacco products as drugs and devices and took jurisdiction over the products. Today, cigarette smoking is still the number one *preventable* cause of morbidity and mortality (US Department of Health and Human Services, 1994). Collectively, health education associations are committed to the efforts aimed at reducing tobacco use in all age groups, as well as preventing initiation of tobacco use by youth. The following areas are important in ensuring comprehensive tobacco legislation: (a) regulation of tobacco products by the FDA; (b) taxation of tobacco products; (c) environmental tobacco smoke; (d) advertising and promotion of tobacco products; and (e) international marketing of tobacco. Two other areas of comprehensive tobacco legislation of specific interest to health educators are public health education and professional education. The following are key items which any comprehensive tobacco legislation passed by congress should include (Advocacy Summit, 1999c):

- Well-funded public education campaigns targeted to adults and children, with particular attention being given to high-risk, special and culturally diverse populations, and which includes tobacco education for all students pre-kindergarten through 12th grades;
- An extensive well-funded counter-advertising campaign that is independent of any tobacco industry control or influence;
- Ongoing research to evaluate and to determine the most effective means of educating the public about the dangers and hazards of tobacco use as well as successful smoking intervention approaches;
- Funding for professional preparation of health professionals with concentration in individual and community-based approaches for smoking prevention and cessation; and,
- Funding for state or local agencies that work with local accredited academic institutions to provide state regional conferences and distance learning programs on state-of-the-art behavioral approaches in tobacco prevention and control.

Tobacco Prevention and Control Appropriations

In addition to comprehensive tobacco legislation, it is also important to have funding at the national and state levels for public education campaigns and school health programs that address youth tobacco use. About 66% of youth currently use tobacco products and more than 3,000 youth start smoking each day (Advocacy Summit, 1999a). The CDC is funded at $73.9 million for fiscal year 1999. An increase in funds for the fiscal year 2000 appropriation of $175 million was supported at the 1999 Advocacy Summit. This increase would help support the CDC in their efforts to provide technical assistance to all 50 states, as well as training on the planning, implementation and evaluation of tobacco control programs for communities and schools.

Diabetes Program

The influence of diabetes on the nation's health can be best understood by examining the complications of the disease. Individuals with diabetes are at risk for blindness, kidney failure, lower-extremity amputation, and cardiovascular disease (CDC, 1999b). Diabetes is the seventh leading cause of death in the United States. The economic burden of the disease approached $100 billion dollars in 1997 (CDC, 1999c). Summit participants supported an increase of appropriations to CDC, state, and territorial-based diabetes control programs.

Education Reauthorization Act

The Elementary and Secondary Education Act (ESEA) supports state and local efforts to improve schools through coordinated, standards-based reforms of teaching, learning, and student achievement. Congress is required to reauthorize ESEA of 1965 every five years. The desired congressional support during this reauthorization period includes the following (Advocacy Summit, 1999d):

- Coordinate school-wide intervention and prevention ef-

forts and provide consultation services by professionals that address both the learning and behavioral needs of students;

· Maintain Safe and Drug-Free Schools Programs. These programs provide leadership in the Department of Education efforts to achieve the Seventh National Education Goal (that by the year 2000 all schools will be free of drugs and violence and the unauthorized presence of firearms and alcohol and will offer a disciplined environment that is conducive to learning);

· Provide support to meet the challenges of incorporating state standards and assessments into classroom instruction and provide all students standards-based curricula, quality instruction, and evaluation and accountability based on these standards;

· Increase support of professional development for teachers, administrators, and all school service personal to improve instruction and learning and increase the coordinated approach to solving school-related problems;

· Take into account the needs of a diverse population, especially those at-risk children and youth; and,

· Support of state and local flexibility but oppose vouchers and block grants when they result in less guidance and accountability.

Patient's Bill of Rights

In November of 1997 the President's Advisory Committee on Consumer Protection and Quality in the Health Care Industry published a "Consumer Bill of Rights and Responsibilities." The Bill of Rights addresses eight areas: (a) access to emergency services, (b) choice of providers and plans; (c) complaints and appeals; (d) confidentiality of health information; (e) consumer responsibilities; (f) information disclosure; (g) participation in treatment decisions; and (h) respect and nondiscrimination. There have been many managed care bills introduced that have addressed several of the above mentioned areas. Yet, most lack the consumer's right to information about his or her condition, treatment, and management. The summit participants not only encouraged legislators to support the Patient's Bill of Rights, but also to support, at a minimum, that consumers have the right to the following provisions (Advocacy Summit, 1999e):

· Receive information about their diagnosis, prognosis and treatment in any language that they can understand including the nature and purpose of the treatment, possible benefits, and known serious side effects or risks;

· Participate in a planned, documented educational program that addresses how to manage and cope with their condition, including relevant information about medications, diet, physical activity, use of medical

Breast & Cervical Cancer Early Detection and Prevention Program

During 1999 an estimated 43,300 women will die from breast and cervical cancer combined. Mammography and Papanicoaou tests (Pap smears) are effective means of detecting breast and cervical cancers in women (CDC, 1999d). Early detection can prevent most cervical cancer deaths and more than 30% of breast cancer deaths. Early detection of these cancers also saves money (Advocacy Summit, 1999f)

In 1999, Summit participants supported an increase of $41 million dollars to the CDC's Breast and Cervical Cancer Early Detection and Prevention. The increase would enhance health education programs related to breast and cervical cancer as well as increase accessibility to screening programs.

Conclusion

Health educators possess the knowledge to make a difference, but will that knowledge be transmitted into action? The process of advocacy is very similar to the process of health education. Bringing the knowledge base of health education and the activism of advocacy together can provide powerful assistance for individuals seeking health and wellbeing. Health educators have opportunities to influence how policy makers think and act on health issues. Advocacy skills provide the necessary tools to broaden the health educator's ability to serve the public. The process of advocacy provides the means of delivering a powerful message. The challenge that remains is cohesive action. If health educators do not work together to inform the policy makers, who will?

References

Advocacy Summit. (1999a). *Tobacco prevention and control appropriations.* [Fact Sheet]. Washington DC: Society for Public Health Educators.

Advocacy Summit. (1999b). *Cardiovascular disease.* [Fact Sheet]. Washington D.C.: Society for Public Health Educators.

Advocacy Summit. (1999c). *Tobacco and health: Key elements of national tobacco control legislation.* [Fact Sheet]. Washington DC: Society for Public Health Educators.

Advocacy Summit. (1999d). *Reauthorization of the Elementary and Secondary Education Act.* [Fact Sheet]. Washington DC: Society for Public Health Educators.

Advocacy Summit. (1999e). *Patient's bill of rights and responsibilities and managed care.* [Fact Sheet]. Washingt-on DC: Society for Public Health Educators.

Advocacy Summit. (1999f). *Breast and cervical cancer appropriations.* [Fact Sheet]. Washington, DC: Society for Public Health Educators.

Centers for Disease Control and Prevention. (1999a). Chronic disease prevention cardiovascular disease. *Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.* [Online]. Available: http://www.cdc.gov/nccdphp/cardiov.htm. [1999, September 1].

Centers for Disease Control and Prevention. (1999b). Centers for Disease Control National fact sheet. *Centers for Disease Control and Prevention.* [Online]. Available: http://cdc.gov/diabetes/pubs/facts98.htm#cost. [1999, September 1].

Centers for Disease Control and Prevention. (1999c). Diabetes fact sheet. *Centers for Disease Control and Prevention, Office of Communications, Media Relations.* [Online]. Available: http://www.cdc.gov.od.oc/media/fact/diabetes.htm. [1999, September 1].

Centers for Disease Control and Prevention. (1999d). Breast and cervical cancer. *Centers for Disease Control and Prevention, Office of Women's Health.* [Online]. Available: http://www.cdc.gov/od/owh/whbc.htm. [1999, September 1].

Nolte, A.E. (1996). The health education profession the 21st century: Setting the stage. *Journal of School Health, 66* (8), 291-298.

US Department of Health and Human Services (1994). Preventing tobacco use among young people: A report of the Surgeon General. *US Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Promotion, Office on Smoking and Health.* Atlanta, GA: author.

Media Advocacy: A Tool for Health Education

Linda Weiner

Media advocacy is the strategic and broad-based use of media for advancing social or public policy issues (Wallack, Dorfman, Jernigan, Themba, 1993). A long-term objective of media advocacy is to raise the consciousness of media professionals in order to change the practices of policy makers who are influential in structuring the environment in which individual health behavior occurs.

Media advocacy can encompass a variety of goals that are applicable to almost any public health education program. Understanding the public or social policy to be changed or advanced is critical in identifying the audience you would select to try and influence. Media advocacy can be used to shape public perception of community opinion leaders who directly influence policy makers, or it can be used to mobilize the community in general to impact policy makers and opinion leaders. These goals can be accomplished by using media to improve participation of community residents in the policy-making process through testifying at public hearings, writing letters to policy makers, or demonstrating publicly. Media advocacy can be used to enhance adherence to policy by publicizing non-compliance of public health policies and by acknowledging individuals and institutions that have helped in passing or enforcing public health policies.

Media Advocacy Strategy

The key to using media advocacy effectively is to use the media pro-actively. Campaigns of many years ago relied on public service time, but this has diminished substantially. In the 1970s the Federal Communications Commission (FCC) revoked the regulation making public service mandatory for broadcasters. Therefore, public health media advocates have cultivated additional methods of delivering the message; they have learned to be pro-active and frame the issue to their advantage. This has been accomplished by generating news stories, appearing on talk shows, writing newspaper guest columns and letters to the editor, training spokespersons to meet with editorial boards, and using counter advertisements. Although there are many media advocacy strategies, the more basic question is how to gain access to the media.

Gaining Access to Media

The goal of a media advocate is to become a trusted resource to journalists. A certain pinnacle of success has been reached if a journalist calls the public health educator for information, rather than the other way around. Therefore, it is vitally important to cultivate relationships with key journalists.

View the media as a partner. Reporters want to do a fair job of reporting, so respect their objectivity. Present the facts without being overbearing and be prepared to present them with as much information as they request. With limited staff, reporters need assistance in gathering information, so help them set up interviews with key people. Respect their deadlines. Reporters have limited time to develop a story, and if you promise information by a certain date or time, follow through. Be honest with statistics. It is better to say you don't know something than give an answer about which you are unsure. Be confident in approaching reporters. Remember that the health educator knows more about the subject than the reporter. Always acknowledge the media who assist you. Write to the editor of a newspaper or to the Federal Communication Commission if it is radio or television, giving them credit in fulfilling public service commitments. This act will endear you to the media organization and help them remember the health education organization in a positive light.

Another way to gain access for issues of major importance is to meet with newspaper editorial boards, which occasionally meet with community residents and leaders. It is also important to find out the names of news directors and assignment editors and direct press releases to them, as they determine what is news. Even better, find a reporter to champion your cause. If the assignment editor or news director is not interested in the issue, a reporter with strong conviction can help change their mind.

Submitting opinion editorials, which are guest opinion columns on the page opposite from editorials, and writing letters to the editor are other easy access points and good ways to advocate your message. Radio talk shows, which are influential and ubiquitous, provide an opportunity to present a balanced view of public health.

A critical component of media advocacy is to train an appropriate spokesperson to be ready at a moment's notice to respond to the press. These representatives need to be knowledgeable about the issue, and equally important, be able to speak with enthusiasm and conviction. The most effective

method to prepare spokespersons is to provide training workshops regarding how to be an effective spokesperson, using the key issues of your organization as examples.

Developing counter-advertisements to reframe the issue is another crucial component of media advocacy. Counter-advertisements are commercials that counter incorrect views of public health, usually put forth by a corporate industry, such as tobacco or alcohol. The California State Department of Health Services, Tobacco Control Section, has used hard-hitting TV and radio counter-advertisements against the tobacco industry. These advertisements have changed the way people view tobacco and tobacco companies, in turn, impacting tobacco policy. These counter advertisements also have been influential in lowering the rate of smoking in California during the early years of the campaign (Pierce et al., 1994).

When the first tobacco counter-advertisement aired in 1988, showing a smoky room full of tobacco executives exclaiming their cynical desire to replace dead smokers with new ones, some stations refused to air the spot because it was controversial in its bias against the tobacco industry. Media advocates seized the opportunity to obtain media exposure by taking advantage of the refusal to air the advertisement as a news story in itself, thus getting more coverage than if the advertisement had quietly aired. Over a decade later, public health media advocates continue to score victories over the tobacco industry through the strategy of counter-advertisements.

Through the tireless efforts of tobacco control health educators, California governor Gray Davis approved the airing of television advertisements that had been produced several years ago, but denied airing by the previous administration. These ads used footage directly from national news stories of tobacco executives swearing before a congressional committee that tobacco is not addictive. Using this footage was an extremely effective method of getting the message across in a straightforward, credible manner, discrediting the opposition, and, incidentally, saving money in television production costs.

Tobacco is not the only issue where counter-advertisements have been used successfully. Violence prevention campaigns in California have used public service announcements to counter the myths that persist about gun violence. They have focused their message at gun manufacturers, thus re-framing the message away from the people who use the guns to the people who make the guns. The idea is not to blame the victim, but to re-focus the issue to accessibility and availability of guns.

One way to generate news about public policy is to hold a news conference, but there is always a risk of breaking news interrupting the press conference. If a news conference is held, be sure that the message is newsworthy by releasing new data, issuing a new report, or localizing national or regional news to make it relevant.

Having a community resident to speak at a news conference about how they have been affected by a health problem or policy can be powerful. At a news conference issuing a report on second-hand smoke, waiters and waitresses in California spoke about the effect of working in a smoky room, hours on end, and how a ban on smoking in bars would be beneficial to their health. This got the reporter's attention.

Another way to generate news is to bring the news to the journalists. Often times, journalists are too busy to leave the news room; therefore, bring the news to them by offering to accompany key people in a news story to their office for an interview.

The final strategy in gaining access is the central element of media advocacy — seizing opportunities to use the news and shape the debate. A key statistic to remember is that 80% of all news is not 'hard' news, such as earthquakes, terrorism, and wars. Most news stories are issues generated and promoted by people in the community. To be newsworthy, the issue should be significant, unusual or unique. It's also helpful if the information is local, timely, urgent or useful. Additional newsworthy qualities include information that affects a specific population or information that affects a large number of people.

There are a myriad of other examples of public health advocates using the news and media in general to shape the debate on their specific issue. Community AIDS activists throughout the country have been vigorous in obtaining expanded TV and newspaper coverage in order to influence key policy holders on issues of medical access, drug accessibility, and increased resources. Local coalitions in Detroit and San Francisco have used the media to shape public opinion and influence local elected officials in reducing alcohol billboards and liquor outlets in low-income neighborhoods. Public housing coalitions in Chicago have used the evening news to force the bureaucracy to change their inhumane housing policies.

The key elements to remember in gaining the media's attention are to be creative, by generating your own news, and to seize opportunities to piggyback on existing news. Finally, also important in achieving credibility is to involve members of the community in approaching and using the media.

Table 1

Media Advocacy Resources

Media Guide for Academics
Foundation for American Communications
85 South Grand
Pasadena, CA 91105
Phone Number: 626-584-0010
$10.00

Outreach TV: Creating Community Campaigns
Benton Foundation
Washington, DC
Phone Number: 202-638-5770
(Available January 2000)

Advocacy Video: Producing Change
Benton Foundation
Washington, DC
Phone Number: 202-638-5770
(Available January 2000)

News for a Change: An Advocate's Guide to Working with the Media (1999)
Allack, L., Woodruff, K., Dorfman, L., & Diaz, I.
Sage Publications
http://www.sagepub.com/

After gaining access, what is the best way to frame the issue? Media advocacy offers specific strategies to get your story across.

Framing the Issue

Wallack, Dorfman, Jernigan, and Themba (1993) addressed the topic of framing the issue. Controversy is a good way to get the media interested, but it is critical that the issue be handled with calm conviction, otherwise the health educator may be labeled a 'public health fascist.' Remember, focus on the health of the public.

Anniversaries and milestones are good opportunities to frame your health issue. Celebrating the anniversary of the beginning of a health education program or the passing of a public health policy is a good opportunity to hold a major event to draw the media and frame the issue. Using a major report by which future progress is judged, such as the Surgeon General's report on drinking and driving, is another way to garner news.

Irony is an interesting technique to frame the story. For instance, public attention is drawn to statements like more kids are killed by violence than by disease; more kids recognize Joe Camel than Mickey Mouse; and diet-related diseases are the third leading cause of death, yet relatively little funding is available for prevention.

Celebrity is another means of garnering media attention. This, however, can be tricky unless the celebrity is directly related to the issue. A national rock star was used to promote anti-alcohol messages, until it was found out that a major liquor brand was sponsoring her tour. Personal testimony can sometimes be more powerful than star power, and can be a good way to get media attention, as long as that attention is brought back to the broader policy context.

Another means of gaining media coverage is the use of injustice. The fact that both the alcohol and tobacco industries target youth is a clear injustice that resonates with the general public. A surefire way to get media coverage is to find a local angle. How will a changing national or state policy affect people in the community? How will it affect their pocketbooks and their daily lives?

The idea of a breakthrough is also a possibility. What is new or different in health education or public health? Perhaps focusing the issue on prevention can reverse the idea of a medical breakthrough.

Finally, the angle of seasonal issues as a strategy can be effective. Events such as high school graduation, the first day of school, the first day of summer, the Legislature's annual budget debate, or a major cultural event in the community, are all seasonal and can give a spin to your issue and help make the story newsworthy. The next step is to think through how to develop story elements that best illustrate the issue.

Developing Story Elements

One type of media bite (verbal equivalents of a bumper sticker, succinct statements under 10 seconds), and a mainstay of media advocacy, is the use of social math. This means making data relevant and understandable; turning the abstract into concrete. Social math presents data for social impact in an interesting format. For example, it is more powerful to say, "Every 7 minutes a California youth begins smoking" than to say that a lot of kids smoke. Likewise, stating that "the alcohol industry spends approximately $225,000 every hour, every day, to advertise and promote their product" is more powerful than saying the alcohol industry spends an enormous amount of money on advertising.

Using compelling symbols is another element in developing powerful stories. A legislator being interviewed at a press conference about hand gun control held brass knuckles to the camera and said, "This is a felony." In his other hand, he held a gun to the camera and said, "This is a misdemeanor." His visual representation of the issue clarified it so that people could understand on a visceral level.

How Do You Measure Success?

How do you know if you have been successful using media advocacy? A clear and obvious sign of success is a successful policy change, although it is problematic to ascertain how much direct effect could be attributed to media strategies. There are criteria, however, that can be measured.

It is possible to determine how much coverage the issue has received. Although securing coverage does not guarantee success, and certainly doesn't guarantee that the issue was covered in the appropriate context, it does help track the amount of media exposure. Clipping services can track the frequency of newspaper, television, and radio coverage of an issue. Copies of stories can be made for all formats. If public service announcements or advertisements have aired, radio and/or television station logbooks will have a record of how many times the message aired and when.

It is also helpful to determine whether the story was introduced or followed up with an appropriate favorable comment. How were the stories framed? Was it a positive spin on the public health angle? Did the media advocacy strategies help build community support? Do journalists now call you about health and public health education news?

The media advocate's goal in moving the policy forward is to translate the individual problem to the more comprehensive social issue by presenting a practical solution. This means not "blaming the victim," but looking at a lack of societal resources and inappropriate public health policies. This means advancing appropriate policy through environmental strategies that support behavior change.

Assigning shared responsibility must be openly discussed. The argument most often put forth often by those opposed to public health policy is the concept of free will and free choice of the individual to smoke, to drink, to not take medication, to not wear a helmet, etc. It is necessary to counter the blame-the-victim syndrome because each individual's behavior builds to a critical mass, which affects the public health of the community. Presenting a practical policy approach is central to advancing public health policy. Finally, the media advocate's role is to localize the message because making something relevant to your state, your city or your community will ring true to the residents.

Conclusion

Media advocacy has been most successful in changing policy where there has been clear opposition — tobacco and alcohol industries, and now gun manufacturers. That does not preclude, however, such strategies from being used with other health issues. Indeed, previous success should encourage health educators to expand the media advocacy efforts to other health concerns.

References

Pierce, J., Evans, N., Farkas, A.J., Cavin, S.W., Berry, C., Kramer, M., Kealey, S., Rosbrook, B., Choi, W., & Kaplan, R.M. (1994). *Tobacco use in California and evaluation of the tobacco control program, 1989-1993.* University of California-San Diego.

Wallack, L., Dorfman, L., Jernigan, D., & Themba, M. (1993). *Media advocacy and public health: Blending science, politics, and activism.* Sage Publications: Newbury Park, CA.

Partners for Advocacy: Non-Profit Organizations and Lobbyists

Susan Frelick Wooley, Ph.D., Scott Ballin, J.D., & Sherri Reynolds, BSN, MS

The ability to advocate for personal, family, and community health is one of seven health education standards considered essential for a health-literate person (Joint Committee on National Health Education Standards, 1995). Although the ability to be an advocate is a standard for students in grades K-12, many professionals in the field are reluctant to get involved in advocacy efforts. Often, the perception is that if one does a good job and is involved in a worthwhile project or cause, there is no need to advocate. The worth or value of the project or work will be obvious. That is not reality. Dedicated people work hard on many projects. Within an organization, health education vies with other programs for visibility, influence, time, resources, space, and funding. Bringing visibility to a project helps it gain respectability and resources. In the community, improving and promoting health often requires addressing policy issues and social change as much as individual behaviors. Sooner or later, almost every health educator will engage in advocacy work of some type.

Advocacy is the act or process of advancing or defeating a cause, policy or proposal.

Advocacy issues include more than legislation and regulation. They can include company

policies, community issues and neighborhood projects ... Advocacy is a powerful tool for

producing social change. (American Heart Association [AHA], 1997, p. 7).

Advocacy includes a mix of activities such as coalitions and partnerships, grassroots networks, lobbying, and other efforts to influence decision makers, and the use of media and communications.

Advocacy can involve efforts to influence public policy, including legislation. Individuals can and should be involved in the political process through voting and contacting elected legislators. In addition, being involved in group efforts can strengthen support for a given position. One reason people sometimes join groups is to have more influence on issues of importance to them. Whether you are involved in political processes or not, you are affected by such processes, both as an individual and in your profession. How many times have you complained about actions taken by the school where you study, your employer, or some legislative body at the national, state, or local level? Too often people mutter their complaints to themselves or spout off to someone near by. Neither of those actions will do much to change the situation or influence decisions.

Professional Organizations as Advocates

Many health educators want the professional organizations of which they are members to advocate for health promotion efforts and for the profession. In fact, such advocacy is one of the six key targets needed for moving the profession of health education forward in the 21st Century (National Commission for Health Education Credentialing, Inc [NCHEC] & Coalition of National Health Education Organizations [CNHEO], 1996). In the past two years, the national organizations representing health educators have jointly sponsored two advocacy summits, which included advocacy training by professional lobbyists followed by visits to "The Hill." In addition, the professional organizations are taking steps individually to be stronger advocates for their members. As an example, the American School Health Association has identified advocacy as one of its four key goals for the next three years (American School Health Association[ASHA], 1998). One strategy toward that end is to contract with a lobbyist as a part time legislative consultant. This article will share some perspectives from that experience.

Non-Profit Organizations

Before contracting with a lobbyist, ASHA had to answer several questions and ensure that systems were in place. An initial question was: Can a non-profit organization legally lobby? Free speech provisions of the Bill of Rights allow any individual or organization to speak in favor of an issue. According to the legal definition, lobbying is an attempt to influence legislation. For a communication to qualify as lobbying it must be directed to a member or an employee of a legislative body, express a viewpoint on a piece of legislation, and request specific action with respect to the legislation, usually in support or opposition. To maintain non-profit status, however, there are restrictions on allowable lobbying activities. Non-profits may not endorse or oppose a candidate for elective office, nor may any member, staff person, or volunteer represent an affiliation with the non-profit in any electioneering activity. Even having candidates' brochures available in the office for the public to pick up would

be a violation. Table 1 summarizes allowable and non-allowable lobbying activities by or on behalf of non-profit organizations (AHA, 1997).

Table 1: Examples of Advocacy Activities Allowed and Prohibited by or on Behalf of Non-Profit Organizations.

Allowed	Prohibited
• Write, phone, Fax, e-mail, or telegraph legislators. • Provide technical advice and assistance to legislative bodies.	• Endorse or oppose a candidate. • Threaten that support or opposition of a bill will be communicated to members in a way that suggests endorsement of opposition to the person as a candidate
• Meet with legislators. • Work on and distribute nonpartisan analyses, issue briefs, and studies.	• Use membership or affiliation in any electioneering. • Campaign for or against a candidate.
• Write letters to the editors; appear on radio, television, or web-based talk shows and discuss pending legislation.	• Distribute campaign literature.
• Encourage others to contact legislators.	
• Provide testimony to legislative bodies.	

These prohibitions apply to candidates for elected office, but not for nominees for appointed office (Portman & Jacobs, 1999). Thus, writing in support of a nominee for Surgeon General would be allowable, but writing a letter of endorsement for someone seeking elected office, even if that person has not officially announced his or her candidacy, would not be allowable for a non-profit organization.

The Internal Revenue Service distinguishes between educational activities and political activities. One determining factor is whether the association's activities are based on conclusions drawn from objective evaluation versus unsupported opinion, distorted facts, or negative terms based on emotional feelings (Portman & Jacobs, 1999).

Advocacy Strategy

Before looking for a legislative consultant, ASHA recognized that a lobbyist must be part of an overall organizational commitment to be involved in advocacy efforts. The organization must know what it wants to advocate. ASHA had a long history of adopting resolutions, which are formal statements of positions the organization takes on a variety of issues. (See http: www.ashaweb.org for more information on ASHA resolutions). Once stated, however, these resolutions remained largely unused. The existence of these resolutions has recently given ASHA a starting point in the task of defining what issues to address with advocacy efforts and when to take a leadership role in advocacy. By tying the resolutions (assigned to a Resolutions Committee) to the advocacy work assigned to a Legislative Committee, the resolutions gained a purpose. As a national organization, ASHA gets many requests to sign on to the advocacy efforts of other groups. Such joint efforts can increase an organization's influence, but not all requests fit in with the organization's advocacy agenda. The resolutions help define which issues to support and which to decline. In turn, requests for sign-ons can also highlight the need for new resolutions.

Another piece of an overall advocacy strategy is a system for mobilizing members, supporters, or volunteers to get involved. Among non-profit organizations, including those with a lobbyist, an organization's scope of influence is defined by whether it can produce grassroots action. Before ASHA hired a legislative consultant, its legislative committee organized a network of legislative contacts throughout the United States. ASHA now has at least one person in each state willing to act as a legislative contact. Each legislative contact has received specific instructions on how to organize and activate a state-based networking tree. Therefore, when ASHA calls on the state legislative contacts, they have a statewide networking tree they can contact to encourage grassroots efforts.

Role of a Lobbyist

Without such systems in place, a non-profit organization

should not contract with someone to provide legislative services. If an organization is ready for this step, the organization must be clear about the parameters. At what level does the organization hope to influence policy or legislation — national, state, local, corporate, or institutional? What are the types of issues the organization foresees coming before the decision making body? What is the relationship between this person and the organization? What are the responsibilities and limits of the lobbyist, and what are the responsibilities of the organization to the lobbyist? What financial resources are available (federal grant money may not be used for lobbying activities)?

The American Heart Association lists the following as typical duties of a contract lobbyist include:

- Meeting with decision makers or their staffs to frame legislation or encourage them to support the organization's positions.
- Monitoring legislation and providing updates.
- Tracking votes and positions of decision makers on the organization's issues.
- Notifying the organization of relevant hearings.
- Identifying swing votes on key issues.
- Representing the organization at key meetings, such as coalition or network meetings or public advocacy meetings.
- Working with the organization to develop strategies for advancing its advocacy issues.
- Identifying key coalitions that the organization might want to ally with on important issues.
- Securing invitations to high level events and hearings on key issues for the organization.
- Preparing spokespersons who will testify at hearings

The organization should have a written contract with the lobbyist that specifies the duties expected. An organization might want the lobbyist to perform only certain tasks on the above list or might have additional requests such as preparation of a column for the organization's newsletter. On the other hand, the lobbyist must decide what level of effort is realistic given the amount of money the organization is offering. As with any contract, it is important to clarify mutual expectations in advance, to help ensure smooth relationships. The contract also needs to specify a period of time that the contract covers, with an understanding that at the end of that time, the relationship might end or be renegotiated.

Training

Another crucial piece of an overall legislative strategy is training. This can occur after a consultant is hired, especially if that person will help design or deliver the training. The grassroots advocates need to know how to increase their effectiveness. People who are immersed in a profession often assume that those making laws or enacting policies that govern their practice are knowledgeable about the issues. In realty, most legislators have only a cursory idea of any issue, if they are familiar with it at all. For grassroots advocacy efforts to be successful, those in the field making contact with decision makers must know how to state their case clearly and succinctly.

At the federal level, one rarely has a chance to communicate directly with the elected official. It is safe to assume that the staffer with whom you do have contact knows nothing about the particular issue of concern to you. The majority of staffers at the federal level have been at their job for less than two years, are straight out of college with little post college life experience, and receive over 200 contacts with the public during a slow week (McLean, 1999). Staffers admit throwing away about 90% of their mail without passing it along (Shipley, 1999). What staffers do pass along is information about the impact of a particular bill – the bill's purpose, any possible negative consequences of its passage, and its significance to the elected official's state or region. Consequently, according to Shipley, (1999, p. 61) training of grassroot advocates should include pointers for getting messages heard, such as:

- Keep the information concise. A written piece should be no more than a one-page bulleted list.
- Localize the message. Indicate how the issue affects the official's constituents. Messages delivered by well-informed constituents carry more weight than do those from outsiders.
- Match messages with job titles. Let press secretaries know of media events and speaking opportunities. Talk to legislative directors about background on issues.
- Provide information to staffers on their terms. Because many staffers are young and work long hours, information available on the Internet, which is readily available to them when they need it, is often more helpful than a stack of papers, which might arrive when an issue is on the back burner.

As partners, lobbyists and non-profit organizations can be effective advocates for an organizations' issues and for issues of importance to a profession. Without the support and direction from the organization and its members, however, the lobbyist cannot work miracles. Organizations cannot idly sit back and expect a lobbyist to look out for their interests. Members of an organization must be willing to respond when the lobbyist alerts the organization to a key vote. Even members who are also government employees (and thus sometimes feel restrained from advocacy efforts) need to remember that they are also citizens. In some cases, these members may be barred from engaging in lobbying activities on company time or using company equipment (telephones, Facsimile machines, computers, and electronic mail accounts), but nothing prevents them from calling or writing as private citizens.

Personal visits and letters tend to be the most effective vehicles for communicating with legislators, although phone calls and FAX transmissions work well before a controversial vote, when legislators want to gauge the level of support for a given issue. Communications in the form of e-mail,

form letters, and petitions are the least influential, but still can convey the level of support.

Conclusion

Engaging in advocacy efforts is for everyone. If you care about an issue, never assume someone else will speak up. This is true whether the effort is undertaken as an individual or as a member of an organization.

If an organization of which you are a member or staff person contracts with a lobbyist, remember that lobbyists can identify actions to take, but it is up to an organization and its members, as well as other interested individuals, to make the contact with decision makers and take the action.

References

American Heart Association. (1997). *Introductory guide to advocacy*. Washington, D.C.:

American Heart Association Office of Public Advocacy. American School Health Association. (1998). Chart ing a course for promoting health through schools: A strategic plan of the American School Health Association. *The PULSE of the American School Health Association, 18* (Winter), insert.

Joint Committee on National Health Education Standards. (1995). *National health education standards: Achieving health literacy*. Atlanta, G.A.: American Cancer Society.

McLean, B. (1999, July 26). Grassroots lobbying on the new Capital Hill. *Telephone* seminar for association professionals sponsored by Association Forum of Chicagoland, The Capitol.Net & KRM Information Services, Inc., Chicago.

National Commission for Health Education Credentialing, Inc [NCHEC] & Coalition of National Health Education Organizations [CNHEO]. (1996). The health education profession the 21st century: Setting the stage. *Journal of School Health, 66* (8), 291-298.

Portman, R. M. & Jacobs, J. A. (1999, June). Knowing your political limits Part I: 501 (c) (3) organizations. *Association Management*, 95-98.

Shipley, D. (1999, June). Breaking through on Capitol Hill: A research-based blueprint can help associations communicate more effectively with elected officials. *Association Management*, 61- 67.

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